DOCUMENT RESUME

ED 307 542 CG 021 712

AUTHOR Craig, Rebecca Tarkington; Wright, Barbara
TITLE Mental Health Financing and Programming: A Legislator's Guide.
INSTITUTION National Conference of State Legislatures, Denver, CO.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, MD.; Robert Wood Johnson Foundation, New Brunswick, N.J.
REPORT NO ISBN-1-55516-679-2
PUB DATE May 88
CONTRACT MH278-86-0005PA
NOTE 159p.
PUB TYPE Guides - General (050)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS *Deinstitutionalization (of Disabled); *Delivery Systems; *Financial Support; Health Care Costs; Individual Needs; *Mental Health Programs; *Policy Formation; *State Legislation

ABSTRACT

This book provides state legislators with the background information they need to make important mental health policy decisions. The executive summary describes the success of deinstitutionalization in releasing large numbers of patients from state mental hospitals, but notes that the needs of persons with mental illness in the community have not been adequately met. It considers state legislative leadership to be particularly important in shaping the mental health system in each state and in meeting the needs of these deinstitutionalized persons. The book is divided into seven chapters. The first chapter provides an overview of the the situation, looking at the role legislators play in mental health, who the mentally ill are and what mental illness is, where the mentally ill are and what services they need, treatment of the mentally ill historically and today, and major issues confronting mental health policymakers. Chapter 2 examines mental health care and treatment and chapter 3 examines mental health service organization and delivery. Chapter 4 discusses the evaluation of mental health programs; chapter 5 focuses on financing mental health care with federal funds; and chapter 6 addresses the financing of mental health care with state, local, and private funds. The final chapter presents future challenges in the field of mental health that state policymakers will face. Creative state approaches are offered throughout the book as strategies to address treatment, delivery, and financing concerns. A list of mental health information sources, a glossary, a list of acronyms used in the book, and a bibliography are included. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

Mental Health Financing and Programming

A LEGISLATOR'S GUIDE

ED307542

CG 021712

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

R. T. Craig

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

National Conference of State Legislatures

The National Conference of State Legislatures serves the nation's 7,461 state lawmakers and their staffs.

NCSL was created in January 1975 from the merger of three organizations that served or represented state legislatures. NCSL is a nonpartisan organization with three objectives.

- To improve the quality and effectiveness of state legislatures;
- To foster interstate communication and cooperation;
- To ensure states a strong cohesive voice in the federal system.

The Conference operates from offices in Denver, Colorado, and Washington, D.C.

Executive Director: William T. Pound

Mental Health Financing and Programming

A LEGISLATOR'S GUIDE

by
Rebecca Tarkington Craig

and

Barbara Wright

National Conference of State Legislatures
William T. Pound, Executive Director

1050 17th Street, Suite 2100
Denver, Colorado 80265

444 North Capitol Street, N.W., Suite 500
Washington, D.C. 20001

May 1988

Financial support in preparing this guide was provided by grants from the Robert Wood Johnson Foundation, Princeton, New Jersey (grant #11893), and the National Institute of Mental Health (contract #278-86-0005PA). The opinions, conclusions, and strategies in the text are those of the authors and do not necessarily represent the views of the Robert Wood Johnson Foundation, the National Institute of Mental Health, and the National Conference of State Legislatures.

Copyright © 1988 by the National Conference of State Legislatures
ISBN 1-55516-679-2

Table of Contents

List of Tables, Figures, and Boxes v

Acknowledgments vii

Executive Summary ix

I Overview 1

The Role Legislators Play in Mental Health 2
What Is Mental Illness and Who Is Disabled? 2
Where Are the Mentally Ill and What Services Do They Need? 4
Historical Treatment of Mentally Ill Persons 6
Treatment of Mentally Ill Individuals Today 11
Major Issues Confronting Mental Health Policymakers 12
Conclusion 14

II Mental Health Care and Treatment 17

Developing a Comprehensive Mental Health System 18
Care and Treatment Issues Confronting State Legislatures 25
Conclusion 32

III Mental Health Service Organization and Delivery 35

Who Provides Services for Persons with Serious Mental Illness? 36
Delivery and Coordination Issues Confronting State Legislatures 42
Conclusion 54

IV Evaluating Mental Health Programs 57
Evaluation and Public Policy 58
Legislative Uses of Evaluation 59
The Legislator's Role in Evaluations 60
Making Evaluations Work 62
Evaluation Through Performance Measures 66
State Approaches 67
Conclusion 71

V Financing Mental Health Care with Federal Funds 73
Federal Sources of Funding 74
Programmatic Barriers to Federal Programs 82
Strategies to Maximize Federal Resources 84
Conclusion 91

VI Financing Mental Health Care with State, Local, and Private Funds .. 93
State, Local, and Private Funding Sources 94
Strategies to Finance Mental Health at the State and Local Levels 99
Conclusion 113

VII Future Challenges 117
Challenges for State Policymakers 118
Factors Shaping the Future of Mental Health Services 119
The Public Mental Health System in the Year 2010: A Scenario for the Future 122
Conclusion 124

Mental Health Information Sources 127

Glossary 135

Acronyms 143

Bibliography 145

List of Tables, Figures, and Boxes

Figure 1-1	Where the Mentally Ill Reside: Institutionalized Population	4
Figure 1-2	Where the Mentally Ill Reside: Community Population	5
Figure 1-3	Actual Number of Resident Patients at State and County Mental Hospitals	8
Table 2-1	Comprehensive Array of Services and Opportunities for Seriously Mentally Ill Persons	19
Table 3-1	Number of Inpatient Beds per 100,000 Civilian Population and Percent Change in Bed Rate, State and County Mental Hospitals, by State	38
Figure 3-1A	Mentally Ill Nursing Home Residents as a Percentage of All Nursing Home Residents	40
Figure 3-1B	Mentally Ill Nursing Home Residents as a Percentage of All Institutionalized Mentally Ill Persons	41
Figure 3-2A	Average Daily Population: State and County Mental Hospitals	43
Figure 3-2B	Patient Care Staff: State and County Mental Hospitals	44
Table 3-2	Selected State Agency Expenditures on Behalf of Mentally Ill Persons, by State Agency and Program	52
Box 4-A	How Evaluation Helps Legislators Ensure Program Accountability	61
Box 4-B	Pennsylvania Performance Factors, FY 1982-1983	68
Table 5-1	Selected Federal Government Agency Expenditures on Behalf of Mentally Ill Persons, by Agency and State	76
Table 5-2	Reported Medicaid Expenditures	79

Figure 6-1 State-Controlled Revenues for the Mentally Ill: Where the Money Comes From 95

Figure 6-2 Per Capita Expenditures by State Mental Health Agencies for Mental Health Services 96

Figure 6-3 Estimated Expenditures for the Chronically Mentally Ill 98

Figure 6-4 State-Controlled Revenues for the Mentally Ill: Where the Money Goes 103

Figure 6-5 States with Mandated Private Mental Health Insurance Benefits 107

Table 6-1 Types of Sponsors of Reuse of State Hospital Property, 1970-1985 110

Acknowledgments

We would like to thank the two organizations that provided the financing to make this undertaking possible—The Robert Wood Johnson Foundation and the National Institute of Mental Health. Stephen Somers, Kathy Parker, and Linda Aiken at the Robert Wood Johnson Foundation and Jacque Rosenberg-London and Lee Dixon of the National Institute of Mental Health, provided assistance, patience, and encouragement throughout the process. A special thanks to Marty Cohen at the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill.

Special thanks are due to Gail Toff Bergman and Leslie J. Scallet for their significant contributions to the document. Ms. Bergman, M.A. in Health Administration, is a consultant in state mental health policy and has been the writer and editor of State Health Reports: Mental Health, Alcoholism and Drug Abuse at the Intergovernmental Health Policy Project for five years. Ms. Scallet, J.D., is the executive director of the Mental Health Policy Resource Center, a new program designed to improve the knowledge base for mental health policy decisions, and has worked in national mental health policy for more than 15 years. Ms. Bergman contributed to the research and writing of the "Overview" and Ms. Scallet composed "Future Challenges."

We would also like to thank the following individuals who reviewed the document and offered insightful comments: Bruce Berger, Colorado Division of Mental Health; Barbara Dickey, Ph.D., Massachusetts Mental Health Center; Howard Goldman, M.D., Ph.D., Mental Health Policy Studies; David Goodrick, Ph.D., National Technical Assistance Center for Mental Health Planning; H. Stephen Leff, Ph.D., Human Services Research Institute; John Talbott, M.D., Mental Health Policy Studies; Barbara Hancock, Colorado Alliance for the Mentally Ill; James Stockdill, National Institute of Mental Health; and Rick Tully, Ohio Department of Mental Health.

Finally we would like to thank the staff at the National Conference of State Legislatures. Candace Romig, director of the Human Services Department, and Martha King, senior staff associate of the Mental Health Project, spent many hours reviewing each draft. Joanne Ourada, administrative assistant for the Mental Health Project, supervised the document's production and Julie Carpenter oversaw the document's graphics. Shirley Michaels edited the guide.

Executive Summary

The mental health system in the United States is in transition from a system that relies on long-term hospitalization of patients in large state institutions to one that emphasizes cost-efficient care in the community. The impetus for this transition—the 25-year-old reform called deinstitutionalization—has been successful in releasing large numbers of patients from state mental hospitals and diverting admissions. However, the second phase of the reform—meeting the needs of persons with mental illness in the community—has fallen short of its goal. Major service gaps include a lack of safe, affordable housing; insufficient job training and employment opportunities; scarce outreach or follow-up programs; and limited services for special populations, such as people with mental illness who are homeless, children, elderly, or substance abusers.

State legislative leadership is particularly important in this time of transition. Policy decisions by legislators help define and shape the mental health system in each state. Lawmakers establish laws, review agency budgets, set performance standards, and create or abolish programs. Most importantly, legislators determine the level of funding available for mental health care. This book attempts to provide legislators with the background information they need to make important mental health policy decisions. The book is divided into seven chapters: Overview, Mental Health Care and Treatment, Mental Health Service Organization and Delivery, Evaluating Mental Health Programs, Financing Mental Health Care with Federal Funds, Financing Mental Health Care with State, Local and Private Funds, and Future Challenges. Creative state approaches are offered as strategies to address treatment, delivery, and financing concerns.

In the area of care and treatment, states such as Arizona, California, Minnesota, Ohio, and Pennsylvania are trying to develop a continuum of care for individuals who are psychiatrically disabled to provide the services and supports they need in the community. This helps reduce the use of hospital care. Responding to confusing commitment procedures and increased usage of hospitalization, some states have simplified commitment procedures and developed alternatives to inpatient care. Georgia, Hawaii, and North Carolina have amended involuntary outpatient treatment laws, providing the courts with the option of outpatient rather than inpatient treatment for individuals with serious mental illness who are resistant to treatment orders. Maine's two-part crisis stabilization program enables persons experiencing acute mental illness to receive 24-hour crisis and respite care without

having to be hospitalized. New Jersey's revised commitment laws require counties to provide screening and short-term treatment facilities to reduce inappropriate hospitalization.

To address the housing needs of individuals experiencing mental illness, over three-quarters of the states have passed laws that prevent restrictive zoning and similar exclusionary practices against group homes. At least half of the states have removed local barriers by broadening the definition of a family to include inhabitants of group homes. States have intervened in siting battles by establishing a specific site selection process for group homes that involves both the group home operator and the local municipality. States are focusing on housing programs that provide stable living arrangements for individuals with mental illness to make their transition into the community easier. States such as Connecticut, Michigan, and Vermont are turning away from traditional residential models, which are often heavily congregated and maximize dislocation, and moving towards more innovative approaches, such as arrangements that support clients in their choice of housing and temporary residences in private homes.

In the area of service organization and delivery, some states are developing a single point of programmatic and funding authority. Wisconsin and Ohio have invested service delivery and funding responsibility at the local level, including inpatient and outpatient funds. In Rhode Island, the executive director of the state mental health agency has line authority over hospital and community programs and can shift savings to community programs that reduce hospital admissions. Nine cities funded by the Robert Wood Johnson Foundation are creating local mental health authorities to consolidate planning, fiscal management, and service coordination for individuals with psychiatric disabilities.

To coordinate services for special populations, such as individuals with mental illness who also are substance abusers, homeless, offenders, elderly, or children, states are developing cooperative agreements to bring together the many different agencies required to meet the diverse needs. In Maine and Ohio, special interdepartmental groups meet the needs of multiproblem youths. Recent California legislation requires a coordinated effort between the department of corrections and the state mental health department to meet the needs of individuals with serious mental illnesses who are in jails and prisons. Other states are tailoring programs to meet the special needs of difficult-to-treat clients. New York plans to create a corps of caseworkers to seek out mentally ill homeless individuals on the streets and in shelters. Rockland County, New York, has established an outreach program for persons with mental illness who are substance abusers. Florida has

targeted the long-term needs of senior citizens in a graduated residential and treatment system.

To ensure continuity of care, states such as Vermont and Wisconsin use continuous treatment teams responsible for clients in all settings, including the state hospital. Ohio and Oregon use case managers to make sure clients receive the necessary services to prevent hospitalization. Other states are establishing linkages between community programs and the state hospital, to ensure that discharged patients receive the appropriate follow-up care.

In the area of evaluation, state legislators are becoming increasingly sophisticated about requiring data to measure and compare mental health programs. Colorado, New Jersey, and Pennsylvania require mental health programs to supply ongoing data on program performance or client outcome. In Pennsylvania, these indicators help legislators make budget decisions.

States are initiating strategies to maximize their mental health dollars by leveraging available federal funds, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, and Medicare dollars. Ohio and Pennsylvania have increased the number of eligible individuals through outreach programs, thus shifting some of the costs to the federal government. Massachusetts is upgrading its state mental hospitals to conform to certification standards to become eligible for increased federal reimbursement. Oregon is taking existing state dollars allocated to mental health and using them as a match to access additional federal dollars. By studying the regulatory changes and "fine print," some states are increasing federal funding for certain categories of patients. Other states are capturing existing grants and housing resources from federal programs to fund residential, supported-employment, and other programs for individuals with psychiatric disabilities.

States also are instituting strategies to make the most efficient use of state-controlled mental health dollars. Demonstration projects in Greater Rochester, New York; Minneapolis, Minnesota; and Philadelphia, Pennsylvania are testing the concept of capitated managed care plans for persons with serious mental illness. States such as Louisiana, Rhode Island, and Texas have instituted programs to shift funds from the hospital to the community. Vermont is considering closing the state hospital to all but the forensic and most-difficult-to-treat clients.

Approximately 27 states have passed laws that mandate private mental health insurance benefits in an attempt to increase the participation of the private sector in funding mental health care. Fifteen states have created comprehensive health insurance associations, known as risk pools, to offer health insurance to otherwise uninsurable people.

Some states, such as Massachusetts, are financing capital improvements to hospitals and community centers by issuing bonds and selling surplus hospital land to developers at a reduced price in exchange for apartment units to be used by clients who are mentally ill. Colorado set up a pooled bond fund to refinance providers' existing debt and build new residential and treatment facilities. In addition, community mental health centers are diversifying into for-profit businesses to help subsidize the public programs.

As the cost of caring for individuals with serious mental illness continues to increase, policy concerns relating to the mental health system will demand the increased attention of state legislators. This guide attempts to outline crucial mental health issues that are confronting legislators today and provide examples of how states are responding to those issues.

I

Overview

Mental illness is no longer an issue discussed behind closed doors. The effects of mental illness are seen each day on the streets of our cities and towns. The members of this disenfranchised group have many faces: inhabitants of downtown street corners, victims revolving in and out of psychiatric hospitals, and nuisance offenders incarcerated in jails, as well as those living productive lives in the community.

In addition to their often disabling illnesses, persons with serious mental illness are subjected to discrimination and poverty. They are disproportionately poor, often lacking the intellectual, psychological, and financial means to lead normal lives. They face daily discrimination in housing, employment, education, and health care. Eligibility standards and administrative regulations often restrict access to critically needed programs and benefits.

With adequate care and treatment, many people with serious mental illness can live satisfactory and productive lives. Good programs and innovative state efforts across the country bear testimony to the fact that it is possible to provide quality services so that many of those afflicted with mental illness can work and live in the community. There is hope and progress—but it is tempered by the availability of resources to care for this often forgotten or ignored population.

The Role Legislators Play in Mental Health

Today, as never before, mental health issues have become top priorities in many state legislatures. Reports of uncoordinated delivery systems, a lack of services, an increase in persons who are homeless and mentally ill, and inadequate funding pressure policymakers to facilitate needed improvements.

State legislatures are involved in every aspect of policy and programming affecting those with mental illness. State lawmakers influence federal funding, establish law, review agency budgets and set appropriations levels, set performance standards, create or abolish programs, and advocate for vulnerable persons with mental illness at the state and federal levels.

Legislatures exert the greatest influence over mental health programming through their power to appropriate funds and to maintain oversight. In an era of consolidation at both the federal and state levels, many legislators are concerned about the allocation of resources and the provision of services to individuals with mental illness. Many state policymakers are taking a closer look at their mental health system in an effort to find some way to design a rational, cost-effective, and high-quality system of care.

What Is Mental Illness and Who Is Disabled?

Mental illness disorders represented the third most costly class of health care expenditures in 1980. Only circulatory disorders—including heart disease, stroke and hypertension—and digestive system disorders were more costly.[1] During 1980, total expenditures for mental health care in the United States were estimated to be between $19.4 billion and $24.1 billion.[2] The direct and indirect expenses, such as lost productivity and increased use of social services, are tremendous costs to society. Costs are especially high for the severe mental problems of childhood, which can produce lifelong debilitation.

In the adult population, the most disabling forms of mental illness are schizophrenia and the affective disorders of clinical depression and manic-depressive disease. Affective disorders are characterized by disabling mood changes of severe depression, elation, or both. These disorders also may be accompanied by delusions and hallucinations. Although schizophrenia affects

small percentage of the population, it is the most expensive and devastating of all the mental illnesses. Victims of this disease may experience delusions, visual and auditory hallucinations, thought disorders, and other disruptive symptoms. At this time, there is no effective prevention or cure for these two diseases.

Broadly defined, serious mental illness causes major impairments in functioning for an extended period of time. Persons with serious mental illness often experience periods of health interspersed with acute episodes of illness that leave the person unable to function in the world. Characteristics of serious and chronic mental illness include:[1]

- Difficulty with tasks of daily living;
- Recurrent problems in meeting basic survival needs;
- Extreme vulnerability to stress;
- Lack of either the motivation or the ability to seek help from the outside;
- Tendency toward episodes of "acting out" behavior that may interfere with the well-being of themselves or others;
- Lack of ability to develop personal social networks; and
- Illnesses or disabilities not usually remediable by short-term treatment.

Subpopulations with special and different needs exist within the general population of those with serious mental illness. These groups require not only services individualized to their needs, but also coordination between systems. These special needs groups include the following:

- Homeless—people who experience both mental illness and homelessness, estimated at 125,000 to 250,000 people;
- Dually diagnosed—individuals experiencing two or more illnesses and requiring services from two or more agencies; and
- Children, young adults, and elderly—age-specific populations that require specialized services and care settings.

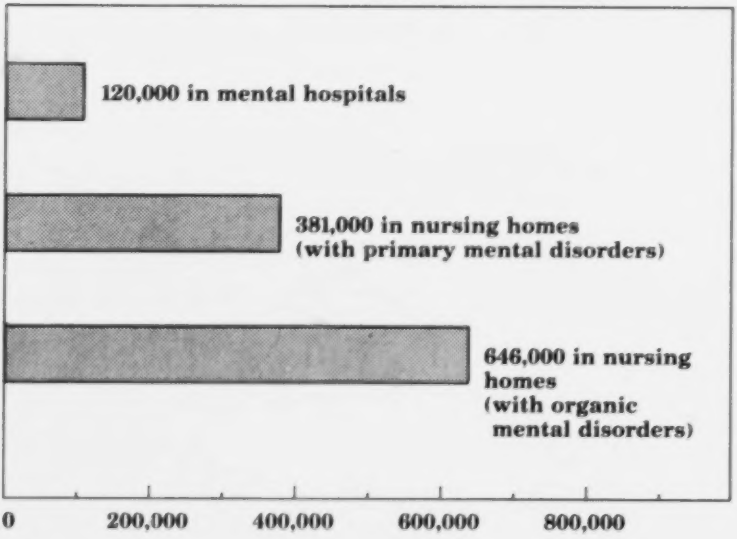
Where Are the Mentally Ill and What Services Do They Need?

Problems in defining chronic mental illness, gathering reliable data, and locating persons with mental illness create difficulties in determining the population's size. Currently there are at least 3 million people in the United States suffering from a severe mental disorder. Of these 3 million, the 1.7 to 2.4 million who suffer prolonged, severe disabilities constitute the seriously or chronically mentally ill population.[4] These people either reside in institutions or live within the community in a variety of residential settings.

Institutional Care. About 1,147,000 persons with serious mental disorders receive institutional care in mental hospitals or nursing homes. Approximately 120,000 are inpatients in long-term care settings, including state and county mental hospitals. An estimated 1,027,000 chronic patients reside in nursing homes.[5] (See Figure 1-1.)

Figure 1-1.

Where the Mentally Ill Reside
Institutionalized Population: 1,147,000

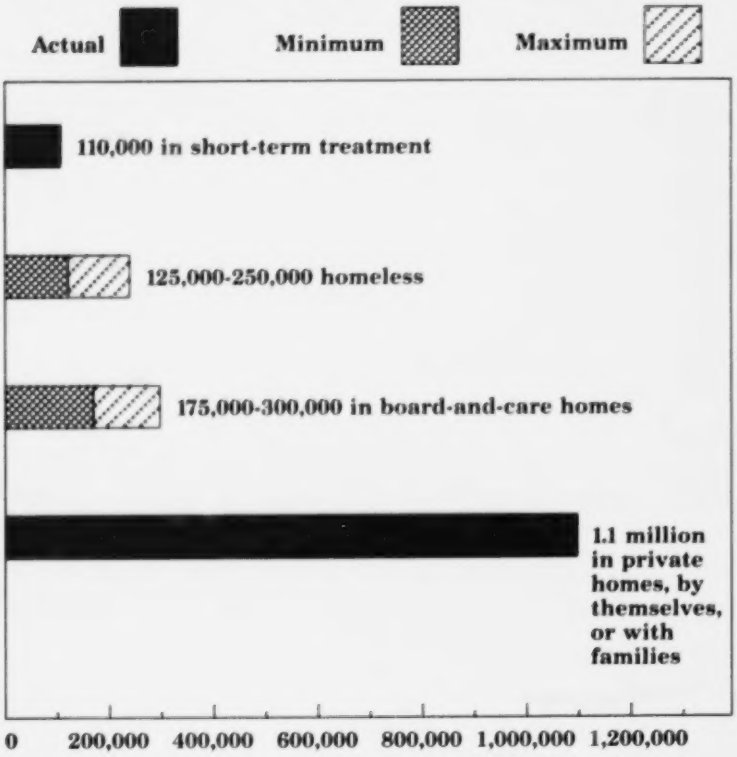


Source: National Institute of Mental Health, 1988.

Community Care. The community population of individuals with serious mental illness numbers approximately 1,635,000. Services used by this population are more difficult to estimate because of the population's mobility and use of many services. Approximately 175,000 to 300,000 of those with serious mental illness live in community residential facilities, such as board-and-care and group homes. Another 1.1 million reside independently or with families, and another 125,000 to 250,000 are homeless.[6] (See Figure 1-2.)

Figure 1-2.

Where the Mentally Ill Reside
Community Population: 1,635,000



Source: National Institute of Mental Health, 1988.

Like the general population, persons with serious mental illness need food, clothing, housing, medical and dental care, transportation, education, recreation, money, and a personal support system. However, these individuals suffer from severe functional disabilities. For this reason, they require distinct, specialized services to meet their unique needs at various times in their lives, including:[7]

- Shelter—an array of special living arrangements designed to provide temporary crisis stabilization, rehabilitation, and long-term support;
- Subsistence—assistance in meeting basic subsistence needs, such as food, clothing, and spending money;
- Medical and mental health care—adequate medical and mental health care, including personnel to work with specialized populations;
- Crisis stabilization—constant crisis assistance with the capacity for onsite assistance;
- Evaluation—comprehensive, realistic evaluation of strengths and weaknesses for the development of plans to achieve goals;
- Socialization—assistance in developing social skills and leisure time pursuits;
- Daily living skills training—training in such areas as cooking, budgeting, transportation, and personal hygiene;
- Employment opportunities—job training and assistance in job procurement techniques; and
- Continuous personal attention—individualized monitoring to ensure needed services are offered.

Historical Treatment of Mentally Ill Persons

With the creation of the state mental hospital in the 19th century, the locus of responsibility for those with mental illness shifted from local communities to state governments. Institutional care was considered an advance in treating persons with mental illness in a cost-efficient and humane environment. These large "asylums" attended to the needs of patients under one roof by providing medical, nutritional, vocational, residential, legal, and economic services.

The federal government did not become involved in the care of those with mental illness until World War II, when large numbers of individuals were rejected or discharged from active duty because of mental or emotional problems. Concern over the prevalence of mental illness, as well as concern over poor conditions in many state hospitals, led to the following actions on the part of the federal government to improve the quality of care provided to persons with mental illness:

- The National Mental Health Act of 1946 marked the beginning of significant federal activity concerning mental health care. The National Institute of Mental Health (NIMH) was created to assist in the development of state and community mental health services, to support mental illness research, and to support mental health professional training.
- The Mental Health Study Act established the Joint Commission on Mental Illness and Health in 1955. The recommendations of this commission in the early 1960s later spearheaded the movement toward deinstitutionalization and community care.
- The Community Mental Health Centers Construction Act began a new era of community care for persons with mental illness in 1963. The majority of funds appropriated under this legislation was for the construction and staffing of the new community system.

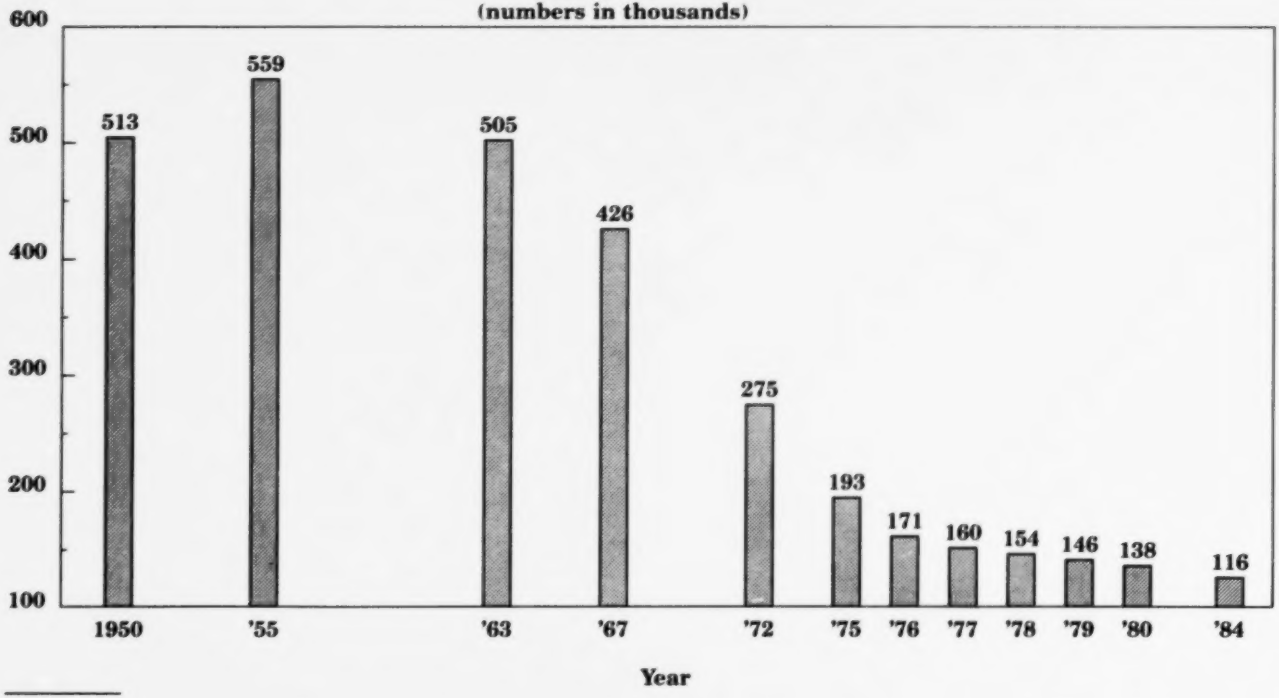
The movement toward community care was based on the premise that more effective care could be provided to most people in a community setting rather than in large state hospitals. At the same time, the development of new psychoactive drugs and treatment modes made implementation of the theory possible, thus providing many patients the opportunity to function outside an institutional setting.

The passage of the Community Mental Health Centers Construction Act accelerated the transfer of patients in state hospitals to community settings. The provision of essential services by community mental health centers supposedly would make this deinstitutionalization process possible by diverting individuals who otherwise might have been hospitalized. The number of inpatients in state mental hospitals in the United States reached a peak of 560,000 in 1955. By 1977, the number of residents had decreased to 160,000. Today, the state hospital population is approximately 120,000, an almost 80 percent decline from 1955.* (See Figure 1-3.)

Other factors contributed to the deinstitutionalization of persons with mental illness. A number of landmark legal decisions

Figure 1-3.

Actual Number of Resident Patients at State and County Mental Hospitals
1950-1984
(numbers in thousands)



Source: Patients in Mental Institutions; unpublished data from the Inventory of Mental Health Facilities, Survey and Reports Branch, Division of Biometry and Applied Sciences, National Institute of Mental Health, update 1988.

made involuntary commitment to mental institutions increasingly difficult. These actions simultaneously affirmed nondangerous individuals' right to freedom and upheld the individual's right to treatment in the least restrictive environment.

The establishment of federal funding sources for persons with serious mental illness—Medicare, Medicaid, and Supplemental Security Income—stimulated state fiscal planners to transfer a large portion of strictly state costs to the federal government. As a result of the federal government sharing at least 50 percent of care expenses, thousands of state hospital patients were "trans-institutionalized" to Medicaid-supported nursing homes. Because little mental health care was rendered in these facilities, nursing homes became inappropriate settings for many with serious mental illness.

During the following 20 years, a series of amendments and refinements were made to the Community Mental Health Centers Construction Act, including:

- The 1970 amendments, authorizing additional federal financial support for community mental health centers located in poverty-stricken areas and for children's mental health; and
- The 1975 amendments, adding new requirements for the organization and operation of community mental health centers, coordination with other entities, and development of an integrated system of care.

Despite these attempts at improvement, reports of an inadequate and uncoordinated service system for the mentally disabled became increasingly familiar. With limited resources and a tendency to compete for easier-to-treat clients, community mental health centers had difficulty providing services for individuals with serious mental illness. Also, limited administrative or clinical coordination existed with the state mental hospitals, since funding for the community centers came directly from the federal government, completely bypassing the state government.

By the late 1970s, a little more than half of the originally projected community mental health centers were funded. Many community mental health centers had difficulties developing alternative sources of financial support as federal funding decreased. Political barriers slowed or stopped the closure of state hospitals, which, in turn, severely limited the resources needed to develop and expand community services. Inadequate community-based services further perpetuated the continued need for inpatient care and the diversion of resources to state hospital maintenance.

In response to these criticisms, the federal government developed two major concepts. NIMH established the Community Support Program (CSP) in an attempt to address the critical needs of people with long-term mental illness in 1977. The program was intended to assist states and communities in developing systems of care that offer an array of services for people with serious mental illness. The CSP has provided small grants to all states over the past 10 years to develop model projects, but budgetary constraints have curtailed the programs in recent years.

In addition, the Mental Health Systems Act of 1980 was passed to develop a federal, state, and local mental health system that ensured coordinated and available service in the community. But the act was never implemented. Less than one year after its passage, a new federal administration pushed through the appeal of all recently enacted service funding provisions, including those in the Mental Health Systems Act.

The Omnibus Budget Reconciliation Act of 1981 created a new block grant for all mental health, alcohol, and drug abuse programs. The block grant was funded at a level 25 percent below previous appropriations. All federal funds were consolidated into one block grant; all funds now go directly to the states. States were given the discretion to allocate resources according to need in the state.

In recent years the federal government has moved on several fronts to improve care for persons with mental illness:

- The Stewart B. McKinney Homeless Act of 1987 (P.L. 100-77) provides both emergency and long-term approaches to housing homeless people, including the integration of mental health services, temporary housing programs with supportive services, primary health services, and demonstration projects to test new approaches for community-based mental health services.
- The Mental Health Planning Act of 1986 (P.L. 99-660) authorizes state grants to develop and implement state comprehensive mental health plans for persons with severe and disabling mental illness.
- The Omnibus Reconciliation Act of 1986, in part, recognizes the chronically mentally ill as a target population under Medicaid.
- The Supported Employment Initiative of 1986 (P.L. 99-506) provided $1.3 million to fund new employment opportunities for persons with serious mental illness through five multiagency projects.

- The Protection and Advocacy for Mentally Ill Individuals Act of 1986 (P.L. 99-319) expands the role of existing statewide Protection and Advocacy (P & A) programs to protect the rights of people with significant mental illness residing in facilities providing care and treatment.
- Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) made several changes to the Medicaid program that affected persons with mental illness, including changes to the home- and community-based services waiver program, as well as the inclusion of case management as a new optional service.
- Child and Adolescent Service System of 1984 supports states in the development of interagency efforts to improve the systems under which the most troubled children and youth receive service.

Despite these significant improvements, the federal role has greatly diminished with the new federalism. Much of the progress made toward developing a responsive mental health system has been reduced, and state governments have been left with the responsibility of picking up the pieces and administering the community programs.

Treatment of Mentally Ill Individuals Today

Today, state mental health systems are in transition. Many attribute the problems that states face to the deinstitutionalization policies of the 1960s and 1970s. The movement achieved its goal statistically: In the past 30 years, the number of state mental hospital residents has decreased by 80 percent.[9] However, the development of an adequate community service system has not been achieved.

Despite uncoordinated and ineffective funding, there is hope that given the right opportunities and the right environment, many individuals with serious mental illness can function independently or with minimal supervision in the community. Hundreds of thousands of persons with serious mental disabilities are helped a great deal by community-based care. Families and consumers are being involved in the mental health treatment and policy

arena. Encouraging efforts are being made at the federal, state, local, and private sector levels to develop increasingly comprehensive and coordinated services systems. These advances offer promise for the future care of persons with serious mental illness.

Major Issues Confronting Mental Health Policymakers

Many of the issues states are dealing with today have been at issue over the past thirty years. Some of these issues reflect problems brought on by the deinstitutionalization policies, while others are directly related to the new fiscal policies and budgetary restraints of the eighties. In some ways, states are looking for solutions to problems that confronted them a generation ago. In other ways, the solutions have become the problems of today.

> A generation ago, many felt that mental hospitals were the problem. Reforms in treatment, programs, laws, and funding were aimed at deinstitutionalization. Now we hear that deinstitutionalization is the problem....A generation ago, many felt that state government was the problem and that the need was for national development, direct stimulation, and "seeding" of initiatives in local communities. Today we hear that the federal government is the problem and the states can and should take the lead in solving mental health (and other social) problems.[10]

Legislators and other policymakers need to be familiar with the major mental health issues to make informed decisions about the system of care. Some of these issues currently facing the states include financing community care while providing necessary resources for inpatient services; revising commitment laws to reflect a balance between rights and needs; providing specialized and coordinated services for children, elderly, homeless, and persons with dual diagnoses in a period of tight budget constraints; developing adequate housing despite intense community resistance; and minimizing discrimination in insurance and other institutional settings. These and other pressing issues are discussed in the succeeding chapters.

Funding. Financing community care continues to be a major issue for almost every state in the nation. States have tried to maximize federal dollars and create innovative financing mechanisms of their own, redesign their mental health systems so that services can be provided more cost-effectively, coordinate service delivery among the various agencies that provide services in the community, develop comprehensive plans to provide a range of community services, or target the development of various care components.

Service Delivery. Many states are seeking ways to integrate inpatient and community-based services. Some state and private initiatives, such as projects sponsored by the Robert Wood Johnson Foundation, are experimenting with centralized systems of fiscal and program authority. Other states are focusing on integrating hospital and community care into a unified, cost-effective system by passing responsibility for hospital funds to local or county boards. Furthermore, administrative regulations have been eased to encourage county/local boards to develop services that provide alternatives to acute hospitalization.

Civil Commitment. The issue of involuntary civil commitment has attracted increasing attention and controversy over the last few years. A number of states have facilitated commitment either by broadening commitment criteria or by easing judicial safeguards. More significantly, several states have modified their "dangerousness" criteria, thus making it easier to commit individuals. In recent years, states have used the criterion of "dangerous to self or others" to permit involuntary commitment. Now two additional criteria, "gravely disabled" and "in need of treatment," are being considered.

Legislation establishing special standards for involuntary outpatient commitment has been passed by some states. These standards are usually more lenient than those established for inpatient treatment. Also, many states are concerned about their commitment statutes for children. Issues related to establishing separate procedures and facilities for children are important to lawmakers.

Special Populations. Coordination of appropriate services to persons with mental illness who are homeless, substance abusers, or incarcerated is another area of concern. Coordination of services is also an issue when developing a continuum of care for seriously emotionally disturbed children and youth, the elderly, persons with dual diagnoses, and others served by several agencies. The mental health system is only one component in a vast continuum of care necessary to meet the needs of these groups. Which agency should have primary responsibility, and how should the various services provided by the different agencies be integrated into an effective continuum are two key questions confronting state planners and policymakers.

Inappropriate and Inadequate Care. States also are concerned about the large number of individuals with mental illness who were transferred from state hospitals to nursing homes, as well as others inappropriately placed in restrictive or inadequate settings. Some states have developed special programs in nursing homes for those with mental illness; others have enhanced the training of nursing home personnel to better serve this population; still others have adopted a special class of residential programs aimed specifically at the needs of this population group. Furthermore, some states provide alternatives to inpatient care through the use of crisis stabilization and other community-based intervention programs.

Other Issues. Each year, state mental health planners and policymakers face these as well as other pressing concerns. Issues related to mandated health benefits in private health insurance are debated each year. The controversy has mainly reflected the traditional stand-off between the insurance industry and the mental health community over the necessity and appropriateness of minimum benefits laws. Patients' rights and prevention issues also are important concerns. Housing for persons with mental illness remains a significant and overwhelmingly important problem as states try to determine how to overcome neighborhood opposition and restrictive zoning, determine the appropriate mix of services, and finance residential programs.

Conclusion

These issues will continue to confront and challenge state policymakers until appropriate solutions are found. In an era of scarce funds, consolidation, and retrenchment, legislators and state planners need to remain open to new strategies and new ideas. As illustrated by the history of mental health services in the United States, many of the "solutions" from the past have created new problems today. It is now important to examine the broader nature of the problem and to devise long-term solutions to the important issues facing every state policymaker dealing with today's mental health care system.

Notes

1. Ronald Manderscheid and Sally A. Barrett, eds., *Mental Health, United States, 1987* (Rockville, Md.: National Institute of Mental Health, 1987), p. 5.

2. Carl A. Taube and Sally A. Barrett, eds., *Mental Health, United States, 1985* (Rockville, Md.: National Institute of Mental Health, 1985), p. vi.

3. Ruth I. Freeman and Ann Moran, "Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization," *Medical Care* 22, no. 12 (December 1984): s10.

4. Manderscheid and Barrett, *Mental Health, United States, 1987*, p. 5.

5. Ronald W. Manderscheid, National Institute of Mental Health, March 3, 1988: telephone interview.

6. Ibid.

7. John A. Talbott, *The Chronic Mental Patient: Problems, Solutions, and Recommendations for a Public Policy* (Washington, D.C.: American Psychiatric Press, 1978), pp. 232-234.

8. Sarah Williams, ed., "Redirecting State Dollars to Build Community-Based Mental Health Systems," *Alpha Centerpiece: A Report on Health Policy Issues* (October 1986): 1.

9. Ibid.

10. Leslie Scallet, Beryl Radin, Thomas Plaut, Stanley Platman, and Chris Koyanagi, "Action for the Future of Mental Health," *Administration in Mental Health* 12, no. 4 (Summer 1985): 223.

II

Mental Health Care and Treatment

The mental health system has changed from one that predominately depends on inpatient hospitalization to one that emphasizes a balance between inpatient, outpatient, and other needed services. Unfortunately, the treatment continuum necessary to successfully sustain persons with serious mental illness in communities has not materialized in many places. Lack of adequate treatment and care has resulted in repeated inappropriate admissions to hospitals and nursing homes, overuse of emergency rooms and hospitals, undue burden on families, homelessness, and repeated encounters with the correctional system.

It is clear that current treatment does not "cure" serious and chronic mental illness. Effective treatment and care, however, enhance the functioning and quality of life for many with serious mental illness. Sufficient community-based services and social support alternatives to long-term hospitalization allow persons with serious mental illness to survive and often to live productive and satisfactory lives in the community.

The first part of this chapter examines the individual service components that make up a comprehensive mental health continuum of care. The second section tackles some of the prominent care and treatment issues confronting state legislatures today, such as zoning, inadequate care, and involuntary commitment. The final section examines strategies and examples that select states have developed to address these pressing issues.

Developing a Comprehensive Mental Health System

Many of the hopes and promises of the deinstitutionalization movement have not been realized. Throughout this massive undertaking, however, certain factors affecting future mental health care policy have become evident:[1]

- Without sufficient resources, simply changing the locus of care will not create good care, as persons with serious mental illness do not automatically improve as a consequence of discharge.
- Mental health systems need to be flexible enough to respond to the cyclical nature of chronic illness and need to aim for a closer integration of institutional and community care systems.
- Mental health programs need inpatient care facilities for acute phases and various levels of community support for outpatient treatment and care.
- Good community care may not cost less than institutional care.

A fully developed continuum of care is needed to effectively respond to the diverse needs required by persons with serious mental illness at varying times in their lives. Such a care continuum includes the following components: a range of inpatient and crisis stabilization services, offered through hospitals, nursing homes, and acute care facilities; vocational skill training and placement services; daily living skill training; social and leisure activities; a spectrum of housing opportunities; medical and mental health care; case management; and a variety of support services. (See Table 2-1.) Unfortunately, availability of these services is often limited or nonexistent in many communities.

Inpatient Psychiatric Care

Patients with serious mental illness may benefit from periods of inpatient care, either on a short- or long-term basis. There are therapeutic advantages to removing individuals from the community when their needs are difficult to meet in community-based programs. State psychiatric hospitals, nursing homes with specialized mental health care, psychiatric units in general hospitals, and community crisis programs provide a range of services to meet the differing needs of the client.

Table 2-1.

Comprehensive Array of Services and Opportunities for Seriously Mentally Ill Persons

Basic Needs/Opportunities

Shelter
- Protected (with health, rehabilitative and/or social services provided on site)
  - Hospital
  - Nursing home
  - Intermediate care facility
  - Crisis facility
- Semi-independent (linked to service)
  - Family home
  - Group home
  - Cooperative apartment
  - Foster care home
  - Emergency housing facility
  - Independent apartment/home (access to services)

Food, Clothing, and Household Management
- Fully provided meals
- Food purchase/preparation assistance
- Access to food stamps
- Homemaker service

Income/Financial Support
- Access to entitlements
- Employment

Meaningful Activities
- Work opportunities
- Recreation
- Religious/spiritual
- Human/social interaction

Mobility/Transportation

Special Needs/Opportunities

Treatment Services
- General medical services
  - Physician assessment and care
  - Nursing assessment and care
  - Dentist assessment and care
  - Physical/occupational therapy
  - Speech/hearing therapy
  - Nutrition counseling
  - Medication counseling
  - Home health services
- Mental health services
  - Acute treatment services
  - Diagnosis and assessment
  - Medication monitoring
  - Self-medication training
  - Counseling
  - Hospitalization: acute and long-term care

Habilitation and Rehabilitation
- Social/recreational skills development
- Life skills development
- Leisure time activities

Vocational
- Prevocational assessment counseling
- Sheltered work opportunities
- Transitional employment
- Job development and placement

Social Services
- Family support
- Community support assistance
- Housing and milieu management
- Legal services
- Entitlement assistance

Integrative Services
- Client identification and outreach
- Individual assessment and service planning
- Case service and resource management
- Advocacy and community organization
- Community information
- Education and support

Source: Henry A. Foley and Steven S. Sharfstein, *Madness and Government*, Washington, D.C.: American Psychiatric Press, Inc., 1983, p. 57.

Hospitals. Traditionally, the public psychiatric hospital played a key role as the primary caretaker for the severely mentally disturbed. These facilities attempted to meet the needs of patients under one roof by providing for medical, nutritional, vocational, residential, legal, and economic services. But improved treatment, expansion of community programs, increased civil rights, and escalating inpatient costs have shifted the primary location of care to the community. Psychiatric inpatient facilities, however, serve as an integral part of treatment and provide an invaluable community service by performing the following functions:[2]

- Hospitalization, when medically necessary;
- Control and security, after legal civil or criminal commitment or as a hospital treatment mandate to influence a voluntary patient; and
- Treatment, if unavailable or unaffordable elsewhere.

Nursing Homes. During the 1960s and 1970s, nursing homes were expected to serve some of the functions previously assigned to state psychiatric hospitals. Unfortunately, patients are often discharged from state hospitals to nursing homes, not because it is the most appropriate placement, but because federal funds available for nursing home placements are not available for other types of community care. Psychiatric treatment and rehabilitation programs frequently are not provided, and many nursing facilities are unable to handle the specialized needs of this disabled population. Recent federal legislation requires that persons with mental illness be screened before admission to a nursing home to ensure appropriate levels of care. Those who do not require nursing care but require active treatment for mental illness must be transferred by the state to a nonnursing facility that provides acute treatment.

Acute and Crisis Care Facilities. Acute care treatment, frequently provided in the community through general hospitals or community mental health centers, has grown significantly in recent years. For individuals with serious mental illness suffering from recurring psychiatric problems and a vulnerability to stress, acute care may be required periodically, often on an emergency basis. Short-term, intensive treatment is provided on an inpatient basis to help patients recover as quickly as possible and to facilitate discharge for further treatment as outpatients. Alternatives to involuntary hospitalization for those in acute mental health crisis are being provided by nontraditional inpatient programs, including emergency crisis teams and foster homes or respite housing with supportive services.

Rehabilitative Services

The most disabling consequence of severe mental illness can be the individual's failure to develop personal relationships, to become involved in the community, and to find a job. The provision of rehabilitation services, such as social, leisure, and employment programs, in conjunction with therapeutic techniques, proves effective in stabilizing and enhancing the lives of those with serious mental illness in the community. Rehabilitative services are especially important following periods of hospitalization or acute episodes of illness. A rehabilitative approach that is able to meet the diverse needs of this population integrates a variety of services, including day programs, vocational skill training, social and leisure activities, and family involvement.

Day Programs. Day treatment programs serve to maintain, stabilize, and prevent decompensation of persons with mental illness through the provision of aftercare services. This program provides a person experiencing mental illness with structure, activity, socialization, and medical and mental status monitoring. Transportation, income maintenance, health care, housing, vocational development, and social activity skills are emphasized. Random studies of successful day treatment programs across the country indicate that the amount of time patients spend in hospitals is significantly reduced and employment prospects are greatly increased when persons are involved in day activities.[3]

Vocational Skill Training. Training and employing those with mental illness are important for two reasons: Integration into the community is increased and reliance on public funds is decreased. Many persons with mental illness experience few successes in mainstream employment and frequently require new opportunities to develop the skills and attitudes needed to succeed in the working world. Recent efforts and approaches, such as supported employment, show promise in expanding the percentage of persons with psychiatric disabilities who are able to achieve their vocational goals.

Vocational rehabilitation for those with mental illness traditionally has involved a three-pronged approach. Following a testing and observation period, appropriate work behaviors and skills are taught in a sheltered workshop. The individual is then placed in a transitional job in the community to further define work behaviors and provide real work experiences. At the end of the placement, the individual can choose another transitional placement, return to any of the skill training programs, request additional training, or move on to competitive employment. For those unable to work full-time, educational opportunities, volunteer work, sheltered employment, or part-time employment should be

available. Sheltered employment programs provide vocational activities in a noncompetitive setting for those unable to maintain a regular job.

Programs such as supported employment, which provide ongoing support services to the persons who are employed and mentally ill, provide successful opportunities for vocationally rehabilitating this disabled population. Under the federal Rehabilitation Act Amendment of 1986, basic Title I state grant funds may be used to place an individual in supported employment and provide postemployment services to that individual. In addition, the new law creates a grant program, administered by the Office of Special Education and Rehabilitative Services, to assist states in developing collaborative programs for training and traditional time-limited postemployment services leading to supported employment for individuals with severe mental handicaps.[4]

Social and Leisure Activities. An individual with serious mental illness lacks confidence in social situations and frequently behaves in a bizarre and unpredictable fashion. Psychiatrically disabled persons often experience difficulties participating in the surrounding community and have few, if any, supports. They need help in finding appropriate activities to develop social skills, leisure time pursuits, and supportive friendships; learning problem-solving and decision-making skills; and participating in educational programs.

Family Involvement. Families of persons with mental illness frequently are primary caregivers and often are the caregivers of last resort. They perform many of the rehabilitative functions necessary for community living. Research indicates important clinical gains in lowered relapse and rehospitalization for many patients when family intervention approaches are utilized.[5] It should be clear, however, that families cannot and should not be responsible for filling in the many gaps of the mental health service network.

For those families with primary care responsibilities, efforts can be made to better utilize their assistance. Family members need crisis intervention services to handle the conflicts and crises that arise in caring for the family member with mental illness. Respite care provides members with needed breaks, while counselors, trained in caregiving and supervising, help with home care. Other forms of education and support are needed to reinforce the vital role families play in rehabilitating persons with mental illness.

Housing

Housing is a critical component of community care. For the psychiatrically disabled, however, the recurrent nature of mental illness often results in the loss of housing and the benefits needed to maintain independent living. Additionally, stigma and discrimination confronted in the community and a lack of needed skills and supports further inhibit successful community living. Without a place to live, the best mental health treatment and the most sophisticated rehabilitation services cannot be effective.

The lack of housing and support services for people with long-term mental illness has reached crisis proportions in many states. In an attempt to address these shortages, some states are moving beyond the traditional housing models of group, foster, and personal care homes to create flexible, stable living arrangements coupled with supportive services. A spectrum of residential arrangements includes crisis intervention; developmental, supportive, and supervised housing; and independent living components. Supports such as income assistance, medication monitoring, skills training, and suppportive counseling provide the assistance necessary to reside successfully in the community.[6]

Crisis Residence. This residence provides 24-hour, quick response crisis assistance and temporary intensive care to help those with mental illness and their families cope with emergencies. Crisis residences serve as an alternative to hospitalization for people who are not dangerous to themselves or others and who suffer periodic crises in their mental illness.

Supervised Residence. Supervised residences house people with significant psychiatric symptoms or social inadequacies. These people may be transferring from a hospital or other programs and require closer scrutiny of the recovery process. This program provides around-the-clock support and supervision. Projected stays range from several weeks to nine months.

Developmental Residence or "Growth House." A "growth house" provides support and active rehabilitation programming but less constant supervision for those who are not as symptomatic or socially disabled. Heavier staffing for weekends and evenings assures continued personal social development through recreation and leisure activities. This program is for individuals who work or attend school or a treatment program during the day. The length of stay usually is from four months to two years.

Supportive Residence. This residence provides support but less constant supervision and less intensive developmental programming than supervised residences or "growth houses." Supportive residences house persons involved in a regular treatment program or vocational activity for one to three years. Evening and weekend

programming is provided. A supportive residence of this type might be a semipermanent living arrangement and serves as a further step toward independence.

Supervised and Supportive Apartment. Supervised apartments offer independent living while maintaining daily staff visits to monitor progress and treatment. Supportive apartments provide supervision as needed and offer more flexibility in developing independence. These apartments may be clustered or scattered throughout the community and may be occupied by one to four individuals depending on size and the degree of solitude or sociability that is needed. Apartments may be leased either in the name of the resident or by the supportive agency, which in turn can collect rent from the tenants.

Resident Congregate Care for Adults (RCCA). Congregate care represents an alternative between the intensively staffed residential housing programs and the minimally staffed supportive apartment. This model is designed for those with mental illness who are unwilling or unable to be involved in any regular day program or activity and who are unwilling or unable to live in an alternative residential setting. Ideally, the RCCA is operated by the same housing agency that operates the other housing levels to allow maximum movement between programs. The RCCA is one step from long-term state institutional care. Placement in this type of large-scale facility should reflect a current psychiatric condition requiring intensive care rather than a lack of residential alternatives.

Supportive Services

In many respects, those with serious mental illness need services similar to the poor in general. In addition to poverty, persons with mental illness are handicapped by impaired judgment in identifying their needs and developing strategies to meet those needs. To maintain a person with serious mental illness in the community, assistance must be available to meet the basic human needs for food, clothing, shelter, personal safety, and general medical and dental care. Assistance is also needed to apply for income, medical, housing, and other benefits to which they are entitled.

Medication Monitoring and Medical/Dental Care. The failure to take antipsychotic medication is one of the most important factors leading to regression and recurrence of psychotic symptoms. However, many patients with serious mental illness discontinue medications once released from hospitals.[7] Medication monitoring encourages continued compliance and ensures the most therapeutic drug regimen for each patient. Some programs are beginning to teach patients to manage their own medication. Individuals with

mental illness require a variety of health services, in addition to medication monitoring. It is recognized increasingly that physical health problems can exacerbate or underlie emotional disturbances. The detection and treatment of health impairments, ranging from vision and hearing problems to chronic illness, are critical.

Mental Health Care. Adequate mental health care includes diagnostic evaluation, prescription and regulation of medication, and community or inpatient treatment. Mental health treatment is often a key factor in preventing expensive hospitalization. Community mental health programs are beginning to shift their service orientation to better meet the needs of individuals with serious mental illness. Services are being expanded to include day treatment, community residential programs, and rehabilitation programs, as well as increased emergency and crisis care.

Case Management. Case management services provide those with serious mental illness with advocacy, continuity of care, and personal help. A single person or team is responsible for providing the kind of individualized and readily available response that is needed to reduce impending crisis and inpatient episodes. These services help a person make informed choices about opportunities and services, assure timely access to needed assistance, provide opportunities and encouragement for self-help activities, and help coordinate all services to meet the individual's needs and goals.

Self-Help and Support Groups. Over the past 10 to 20 years, the self-help movement has led to an enormous increase in the number of support groups for those experiencing mental illness and their families. Such groups provide emotional support and practical help for dealing with problems that members encounter. The National Alliance for the Mentally Ill provides education, support, and advocacy for those affected by mental illness, and the National Mental Health Consumers Association provides consumer-run services as alternatives to the mental health system, in addition to support and advocacy.[8]

Care and Treatment Issues Confronting State Legislatures

Government studies, media and consumer reports, and service professionals have decried the problems wrought by deinstitutionalization and the community placement of persons with serious mental illness. In response to this criticism, state legislatures across the nation are deliberating the complex issues affecting this population. There has been some improvement in mental

health system coordination and service delivery, but few states have comprehensively addressed the needs of this disabled population.

This final section examines some of the major treatment issues facing state legislatures today, including commitment, zoning, and inadequate care. The identified strategies and state examples provide policymakers with concrete approaches for addressing these difficult issues.

Issue: Confusing Commitment Procedures and Increased Usage of Inappropriate Hospitalization

Many mental health practitioners and families find today's civil commitment laws bureaucratic and restrictive. State laws guarantee patient rights that have been derived largely from criminal procedures, including the right to have access to general, legal, and treatment information; the right to counsel; the right to cross-examination; the right to a hearing; and the right to planned and monitored treatment. Yet for many, these safeguards have turned the civil commitment process into a procedural maze and a roadblock for those needing treatment.

In addition, the lack of community resources has created a demand for institutional care. The visible homeless have exacerbated this reaction, since many argue that the rights of those with mental illness are not served by complex laws that sometimes work against the treatment needs of the patient. The growth of advocacy groups for people with mental illness and their families during the last five years underscores a growing concern for adequate treatment for those most-in-need.

State Approaches: Simplify Commitment and Develop Alternatives to Inpatient Care

Although over 75 percent of the states reviewed their commitment laws over the past several years, few states have made sweeping changes.[8] The national trend for involuntary commitment is toward easing judicial safeguards and broadening commitment standards. Moreover, states are focusing less on confrontational, formal commitment procedures and more on acceptable courtroom procedures that increase cooperation among the parties involved.

However, efforts to ease commitment standards are not always in harmony with the need for a continuum of appropriate care and treatment. Easing commitment criteria can result in channeling more money to the state hospital and less to community care that could reduce the need for hospitalization. States are experi-

menting with community alternatives to inpatient psychiatric care, such as community-based crisis programs and outpatient treatment mandates.

Georgia, Hawaii, and North Carolina. Involuntary outpatient treatment laws in Georgia, Hawaii, and North Carolina enable the courts to compel outpatient treatment for persons with mental illness who need treatment but who are incapable of voluntarily complying with treatment orders. As an alternative to involuntary commitment to a psychiatric hospital, crisis programs and other intervention strategies are used to stabilize persons with mental illness before their return to the community.[10]

Maine. With $300,000 from the Maine legislature, the Bureau of Mental Health set up a two-part crisis stabilization program that enables a person with acute mental illness to receive 24-hour crisis and respite care without having to be hospitalized. The Crisis Intervention Program relies on teams of mobile outreach workers who specialize in crisis intervention. Short-term, transitional apartments are available and offer a more attractive, less expensive respite than hospitals for people experiencing a psychiatric crisis. Clients are linked with community-based services such as day treatment, psychosocial rehabilitation programs, and halfway houses for as long as six weeks. In addition, the apartment setting allows for greater family involvement in treatment plans. State officials report that the program is helping to cut hospital admissions and readmissions.[11]

New Jersey. In an effort to ensure clinically appropriate treatment near a person's community, New Jersey revised its laws for commitment of persons with mental illness to inpatient facilities in 1987. In part, each county or region within the state must designate one or more mental health agencies or facilities to provide screening services and to provide short-term care facilities for assessment, treatment, and rehabilitation. These facilities also are responsible for developing discharge plans for each patient. The state hopes that the use of screening and short-term treatment facilities will lessen inappropriate hospitalization and reliance on psychiatric institutions and promote continued care following acute treatment.[12]

Washington. Within the past several years, Washington has set up 12 new residential treatment facilities specifically designed for persons who have spent their lives in and out of state mental institutions. One of the facilities, Program for Adaptive Living Skills (PALS), is located on the Western State Hospital campus; it emphasizes extensive liaison with sponsors and professionals in the communities where the patients eventually will live. Local mental health professionals visit the facility to build trust with the patients with whom they will work after being discharged

into supervised group homes. Various effectiveness tests indicate that PALS residents are progressing slowly, although many residents initially functioned at a low level. The program costs about $80 per day compared to an estimated $120 per day in an adult psychiatric unit. The legislature appropriated $1.1 million to operate the program in 1985 and set aside $2.9 million to convert an additional 250 state hospital beds to similar adult residential programs.[13]

Issue: Exclusionary Zoning and Community Resistance

Over the past 20 years, communities have greatly resisted efforts to integrate individuals with mental illness. Exclusionary zoning has banned small group homes from many residential neighborhoods. Larger facilities have been blocked from locating in better downtown neighborhoods through complicated and often discriminatory zoning regulations that require zoning permits or variances.

While many states have worked to correct exclusionary zoning ordinances, localities have begun to invoke the power of private land use regulations and restrictive covenants to block the establishment of community residences for persons with mental illness. Unfortunately, the small percentage of the communities that did not block such residences have been overrun by them, creating "social service ghettos" and further entrenching resistance to those with mental illness.

In addition to the barriers erected by communities, persons with serious mental illness face further impediments to community integration. Following the depopulation of state mental hospitals, communities failed to develop adequate community support systems, resulting in a severe shortage of resources. The housing market has been depleted by rent increases, the destruction or elimination of many public housing programs, and the preference extended to other disabled populations.

State Approaches: Limit Restrictive Zoning and Develop Community-Accepted, Cost-Effective Housing

State legislatures have acted to address the housing of persons with mental illness in a number of ways. At least 37 states have passed laws, most since 1980, that prevent restrictive zoning and similar exclusionary practices against group homes for those with mental illness. At least 25 states removed local barriers by broadening the definition of a family to include inhabitants of group homes. In addition, some states have tried to protect localities

against the clustering of facilities by overriding all local zoning to force equitable dispersion of group homes or by stipulating distance requirements between residential facilities. States also have intervened in siting battles by establishing a specific site selection process for group homes that involves both the group home operator and the local municipality.[14]

Today, states are focusing on housing programs that provide stable living arrangements for individuals with mental illness and ease their transition into the existing community. States such as Connecticut, Michigan, and Vermont are turning away from the traditional residential models, which are often heavily congregated and staffed, maximize the dislocation of those with mental illness, and incite the greatest community opposition.

Connecticut. As of 1981, Connecticut had 296 community residential slots that were supervised apartments or group/halfway homes. Since that time the state has moved toward a system that supports clients in their choice of housing. The common link in the development of these innovative programs is a commitment to program supports and case management for clients. The new supported housing programs provide a range of housing opportunities and choices and do not require that clients move through transitional programs.[15]

Michigan. In recent years, Michigan has provided more than $30 million to develop residential programming. The state has replicated several residential models across the country, including the Fairweather Lodge model, where clients live and work together as a group; the PACT (Program for Assertive Community Treatment) approach, which provides professional treatment wherever the client is living and emphasizes clinical treatment, medications, and practical support; and supported independent living, in which staff develop working agreements with landlords and families and provide support services that the client may need to retain housing. The state also hopes to provide housing options for the homeless and marginally housed persons through the development of pilot programs.[16]

Vermont. The Specialized Transitional Beds (STB) Program provides temporary residences in private homes for individuals who are ready to leave the hospital and make the transition to community living. Six host families, dispersed throughout a three-county catchment area, maintain homes for placement at anytime. When an individual leaves the STB Program, a staff person from the area mental health center ensures that support networks are available in the community. This rural treatment model has been successful in providing individualized community treatment as an alternative to institutionalization.[17]

Issue: Limited Community Treatment Alternatives

The lack of community-based housing and support services has left the treatment of those experiencing serious mental illness to inadequate, inappropriate service systems. Many communities lack the necessary services and supports to meet the basic life needs of the thousands of patients who were discharged from state hospitals into communities and those who are being diverted from hospitalization today. As a result, many persons with severe and disabling mental illness are left with inadequate acute care and follow-up services.

Major service gaps include the following: a lack of safe, affordable housing, insufficient job training and employment opportunities, scarce outreach or follow-up programs, and few services for special populations, such as children, the elderly, and persons with a diagnosis of mental illness and substance abuse or mental retardation.

State Approaches: Develop Comprehensive Community-Based Care Systems

Several state and national initiatives are beginning to address comprehensively the needs of those with serious mental illness. States such as Arizona, California, Minnesota, Ohio, and Pennsylvania are realizing that a fully developed continuum of care is needed to respond to the complex and diverse needs of this disabled population.

Two national initiatives, funded by the National Institute of Mental Health, attempted to respond to the need for a comprehensive mental health system through minimally funded demonstration projects. The Community Support Program (CSP) for adults and the Child and Adolescent Service System Program (CASSP) for children provided models for delivering mental health services to individuals with serious mental illness. Although the federal government has curtailed these programs' efforts in recent years, the CSP and CASSP approaches are recognized by many as effective and efficient models in treating individuals with serious mental illness.

Arizona. In response to an earlier court decree, Arizona passed a major law in 1986 to promote community-based services within the state. In part, the measure appropriated $3 million to provide enhanced services to those with serious mental illness. Five pilot projects will serve 250 clients through the use of "clinical teams" that provide case management services. The teams are responsible for outreach to homeless shelters and other social service agencies, needs assessment, treatment monitoring, and purchase or provision of needed services.[18]

California. The state enacted the Children's Mental Health Services Act in 1987 to establish and coordinate a service system for children on a voluntary county basis throughout the state. This legislation was based on the effectiveness of a demonstration project that produced a comprehensive services system for children and increased interagency collaboration. This system enabled the child to remain at home whenever possible, provided placement in the least restrictive and least costly setting consistent with the child's needs, and enabled the child to receive out-of-home services as closely as possible to the child's residence. Each participating county will phase in over three years the following components:

- Case management and other needed services, as defined by each county;
- Services for children who are the most difficult to place and services that permit the child to reside in the family setting, when in the interest of the child;
- Use of existing service capabilities within various community agencies;
- Interagency collaboration by all publicly funded agencies and written interagency protocols and agreements; and
- Services provided in the least restrictive setting consistent with effective services and as closely as possible to the child's residence, when out-of-home care is indicated.[19]

Minnesota. Minnesota responded to reports of a state nonsystem of care for those with mental illness by passing a major legislative initiative in 1986. The state is mandated to develop a comprehensive system of mental health services. Almost $15 million of new monies was allocated to provide services within the state. Each county board of commissioners is required to develop the following services: education and prevention services, emergency services, outpatient services, community support program services, residential treatment services, short-term hospital inpatient treatment services, and regional treatment center inpatient services. In addition, all counties are required to develop case management services and day treatment activities for all county residents having serious and persistent mental illness. Funds also were provided to monitor and enforce the achievement of a comprehensive mental health system by 1990.[20]

Ohio. Three of Ohio's metropolitan areas—Toledo, Columbus, and Cincinnati—have been awarded grants from the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill to support the development of a range of community services and

supervised housing. Through the grant and other state initiatives, the Ohio Department of Mental Health is coordinating the development of an innovative mental health services continuum for people with serious mental illness, including providing alternative housing to traditional group homes, restructuring treatment with assertive outreach services in the client's living environment, and expanding vocational rehabilitation opportunities to enable individuals with mental illness to meet their employment potential.[21]

Michigan, Pennsylvania, Utah, and Virginia. Under the Federal Rehabilitation Act Amendment of 1986, Michigan, Pennsylvania, Utah, and Virginia have received funding to develop supported employment programs for individuals with serious mental illness. Supported employment involves matching a client to a job and using staff support to train the participant and supplement necessary production. Although initial costs of maintaining a participant on a job are high, the public dollar cost in Pennsylvania, for example, dropped rapidly after the first year to approximately $2,000. This cost is significantly less than the cost of maintaining the same individual in sheltered employment or other treatment programs at approximately $7,000 per year.[22]

Conclusion

The mental health policies of the past two decades and the evidence of unserved populations suffering from serious mental illness constitute a public health crisis. Policymakers need to investigate the costs of providing—and not providing—services for those with serious mental illness in community and inpatient settings. Research indicates that new treatment approaches and techniques are effective in maintaining persons with serious mental illness in the community. At the same time, comprehensive services produce significant savings through reduced usage of expensive inpatient options and other forms of medical care. Without adequate care and treatment, however, the direct and indirect costs of mental illness soar. Development of comprehensive services may appear expensive, but the present lack of such services also is costly.

Notes

1. Ruth I. Freeman and Ann Moran, "Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization," *Medical Care* 22, no. 12 (Supplement) (December 1984): s20.

2. Ronald J. Diamond, "The Role of the Hospital in Treating the Chronically Disabled," Leonard Stein, ed., *New Directions for Mental Health Services: Community Support Systems for the Long-Term Patient* (San Francisco: Jossey-Bass, 1979), p. 53.

3. Robert Paul Liberman et al., *Resource Book for Psychiatric Rehabilitation* (Camarillo, Calif.: Center for Rehabilitation Research and Training in Mental Illness, UCLA School of Medicine, 1984), pp. x2-x52.

4. Kathy Furlong-Norman, ed., "Supported Employment for Psychiatrically Disabled Adults," *Community Support Network News* 3, no. 4 (April 1987): 6.

5. Freeman and Moran, "Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization," p. s54.

6. The following section is drawn primarily from Bert Pepper's "Where and How Should Young Adult Chronic Patients Live? The Concept of a Residential Spectrum," *TIE Lines* 2, no. 2 (April 1985): 3-4.

7. Liberman, *Resource Book for Psychiatric Rehabilitation*, pp. 1-18.

8. For additional information on self-help and support groups, contact the following: The National Alliance for the Mentally Ill, Suite 500, 1901 North Ft. Myer Drive, Arlington, Virginia, 22209, (703) 524-7600 and The National Mental Health Consumers' Association, 311 South Juniper Street, Room 902, Philadelphia, Pennsylvania, 19107, (215) 735-2465.

9. Rebecca Craig and Andrea Paterson, "State Involuntary Commitment Laws: Beyond Deinstitutionalization," *State Legislative Report* 10, no. 6 (revised March 1987): 6-9.

10. Ibid., p. 7.

11. Patrick Rogers, ed., *Trends and Innovations in Mental Health* (Arlington, Va.: Capital Publications Incorporated, 1986), pp. 75-77.

12. New Jersey 1987 Laws, Chapter 116.

13. Rogers, ed., *Trends and Innovations in Mental Health*, pp. 81-82.

14. Joann S. Lublin, "Group Homes that Serve the Mentally Ill Face New Barriers in Some Communities," *Wall Street Journal*, December 16, 1986, p. 37.

15. Priscilla Ridgway, "Housing and Mental Illness," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 35 (November/December 1987): 9.

16. Ibid., pp. 9-10.

17. Kathy-Furlong Norman, ed., "Host Homes in Rural Vermont," *Community Support Network News* 1, no. 4 (November 1984): 4.

18. Gail E. Toff, ed., "Arizona Legislators Respond to Landmark Court Decision with New Services for the Chronically Mentally Ill," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 24 (June 1986): 1-3.

19. California 1987 Statutes, Chapter 1361.

20. Rebecca Tarkington Craig and Michelle Kissell, *1986-1987 Mental Health Issues and Select State Responses* (Denver, Colo.: National Conference of State Legislatures, August 1987), p. 12.

21. Gail E. Toff, ed., "Ohio Considers Legislation to Decentralize its Mental Health System," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 33 (August 1987): 1-3.

22. Norman, ed., "Supported Employment for Psychiatrically Disabled Adults," pp. 6-11.

III

Mental Health Service Organization and Delivery

The mental health system in many states is a chaotic collection of diverse programs, rather than a coordinated system of care. Each program may have its own eligibility requirements, regulations, policies, and funding sources. As the patient moves among treatment settings, a different agency or level of government assumes responsibility for funding and caring for the patient—but no one authority has ultimate responsibility.

Many states are now realizing that inadequate and uncoordinated care results in individuals with psychiatric disabilities not receiving treatment appropriate to their needs. Fragmented care results in unnecessary duplication of services in some areas and a paucity of services in others. In addition, it poses barriers to clients and family members trying to gain access to services. Areas that have little, if any, continuity of care between hospital and community programs may experience unnecessary hospital admissions and individuals discharged into the community without sufficient follow-up care.

This chapter examines mental health service organization and delivery, and state strategies for coordinating services. The first section discusses public mental health service providers. The second section examines organizational and service delivery issues confronting state legislatures, including structural deficiencies that prevent the mental health dollar from following the patient; the inability to coordinate the many agencies involved in delivering mental health services to children, the homeless, substance abusers, or the elderly; and ways to provide a continuum of care to clients using services funded and administered by different agencies and levels of government. Innovative state programs that have addressed these issues are offered as models.

Who Provides Services for Persons with Serious Mental Illness?

A variety of federal, state, and local agencies and programs deliver services to persons with mental illness in the public sector: state mental hospitals, general hospitals, nursing homes, community-based mental health programs, community support programs, other public agencies and the criminal justice system. This section outlines the major providers of mental health services and the general movement of clients between sites of care.

State Mental Hospital. The state hospital provides acute and long-term inpatient care for individuals suffering from the most serious mental illnesses. In most states, patients are funneled to the state hospital from community mental health centers, general hospitals, the criminal justice system, and private hospitals and psychiatric institutions, which often transfer patients whose private insurance has expired. Patients involuntarily committed through civil or criminal procedures accounted for half of all admissions in 1979.[1]

Because the major costs of mental health care are fueled by excessive hospitalization, policy in most states favors reducing inpatient care when possible. Over the past 10 years, the number of mental hospital beds per 100,000 population declined by as much as 88 percent in some states.[2] Table 3-1 gives a state-by-state breakdown of bed reduction. Mental health clients are increasingly treated in the community rather than the hospital.

Although long-term inpatient care is still needed by a few, hospital stays tend to be shorter today. When a patient is admitted to the mental hospital today, he is likely to remain there a few

days or weeks rather than months or years.[3] The reasons for shorter stays include high costs and court cases that mandated specific levels of care in state hospitals and treatment settings that are "least restrictive."

For the consumer, reduced admissions are a mixed blessing. Shorter stays result in less disruption to the person's life. However, in many areas, the state hospital's link to community programs is not strong enough to assure that discharged patients receive the follow-up care that they need to cope with the stress of daily life. On their own, many persons with psychiatric disabilities do not know how to obtain the treatment they need, even when the necessary community programs exist. Without treatment, the person suffering from mental illness is more likely to have a serious recurrence of the illness, making it necessary to re-enter the hospital.

General Hospitals. During an acute psychotic episode, a person with mental illness may seek help at a general hospital emergency room. This is a convenient, accessible entry point, and Medicare and Medicaid reimbursements are available to eligible patients. However, these hospitals frequently are not equipped to provide care for persons with serious mental illness. Only 17 percent of the country's 5,904 general hospitals have psychiatric services, and only 14 percent have a separate psychiatric unit.[4] Forty percent of all inpatient episodes for mental problems occur in general hospitals without psychiatric units.[5] Patients who seek treatment at a general hospital without a psychiatric unit may receive treatment from a doctor with no mental health training. This raises questions about quality of care and appropriateness of admission and treatment.

From the general hospital, some persons with mental illness are channeled to the state hospital for long-term care or to community mental health centers, depending upon the severity of their symptoms. If no coordination exists between the general hospital and community programs, the client may not receive the follow-up services needed to maintain stable functioning. As a result, he may wander the streets, live with a family unequipped to provide for his needs, or cycle in and out of hospitals.

Nursing Homes. Today, the majority of long-term custodial care for persons suffering from mental illness is provided by nursing homes. Approximately 1,027,000 persons, or two-thirds of all nursing home residents, suffer from mental illness. This figure includes 381,000 elderly with a primary psychiatric diagnosis and 646,000 with a physical and mental disorder, especially senility without psychosis.[6] (See Figures 3-1A and 3-1B.)

Nursing home residents who suffer from mental illness receive little treatment for their disease, because nursing home staff are

Table 3-1.

Number of Inpatient Beds per 100,000 Civilian Population and Percent Change in Bed Rate, State, and County Mental Hospitals, by State: United States, January 1974, 1983, and 1984

State	Inpatient Beds per 100,000 Civilian Population			Percent Change in Bed Rate	
	Jan. 1974	Jan. 1983	Jan. 1984	1983-1984	1974-1984
Alabama	139.1	56.8	57.9	1.9	−58.4
Alaska	65.1	34.7	35.7	2.9	−45.2
Arizona	42.6	12.0	14.2	18.3	−66.7
Arkansas	82.3	16.4	16.6	1.2	−79.8
California	52.7	27.4	26.0	−5.1	−50.7
Colorado	64.5	32.4	29.3	−9.6	−54.6
Connecticut	121.5	76.2	76.5	0.4	−37.0
Delaware	242.5	103.7	88.1	−15.1	−63.7
Dist. of Columbia	472.9	335.6	258.6	−23.1	−45.3
Florida	119.8	44.2	43.2	−2.3	−63.9
Georgia	188.0	85.4	75.6	−11.5	−59.8
Hawaii	28.4	24.3	24.9	2.5	−12.3
Idaho	44.6	26.8	23.1	−13.8	−48.2
Illinois	92.3	36.1	35.7	−1.1	−61.3
Indiana	140.1	55.5	46.7	−15.9	−66.7
Iowa	55.1	36.8	33.1	−10.1	−39.9
Kansas	86.8	56.1	53.5	−4.6	−38.4
Kentucky	60.1	24.4	25.3	3.7	−57.9
Louisiana	108.6	48.5	43.3	−10.7	−60.1
Maine	127.3	59.3	57.5	−3.0	−54.8
Maryland	169.5	81.6	80.4	−1.5	−52.6
Massachusetts	139.6	48.3	48.1	0.4	−65.5
Michigan	88.8	46.8	48.7	4.1	−45.2
Minnesota	114.9	52.4	38.9	−30.0	−68.0
Mississippi	217.7	81.2	79.7	−1.8	−63.4
Missouri	106.4	48.2	47.8	−0.8	−55.1
Montana	174.5	50.4	49.9	−1.0	−71.5
Nebraska	66.1	44.5	41.8	−6.7	−31.8
Nevada	81.4	20.3	10.3	−49.3	−76.1
New Hampshire	198.2	33.8	55.3	−63.6	−88.0
New Jersey	192.7	68.0	65.3	−4.0	−68.4
New Mexico	33.1	19.4	20.6	6.2	−37.9
New York	271.0	144.7	151.5	4.7	−44.1
North Carolina	129.3	57.2	40.2	−29.7	−68.9
North Dakota	151.7	114.9	111.4	−3.0	−26.5
Ohio	137.3	49.9	44.3	−11.2	−67.7
Oklahoma	124.9	51.9	47.6	−8.3	−61.9
Oregon	74.2	35.8	34.8	−2.8	−53.1
Pennsylvania	182.6	84.5	85.7	1.4	−53.1
Rhode Island	201.8	73.2	46.9	−36.0	−76.8

State	Inpatient Beds per 100,000 Civilian Population			Percent Change in Bed Rate	
	Jan. 1974	Jan. 1983	Jan. 1984	1983-1984	1974-1984
South Carolina	215.5	113.7	101.8	−10.5	−52.8
South Dakota	171.2	65.4	62.4	−4.6	−63.6
Tennessee	134.8	49.7	43.8	−11.9	−67.5
Texas	99.3	44.0	41.1	−6.6	−58.6
Utah	28.4	20.0	19.5	−2.5	−31.3
Vermont	142.5	50.0	35.0	−30.0	−75.4
Virginia	176.1	91.3	72.5	−20.6	−58.8
Washington	62.0	28.5	31.2	9.5	−49.7
West Virginia	230.1	79.9	34.7	−56.6	−84.9
Wisconsin	149.4	25.9	24.4	−5.8	−83.7
Wyoming	117.0	68.5	78.1	14.0	−33.2
Totals	**132.4**	**58.1**	**55.4**	**−5.2**	**−58.4**

Source: "State and County Mental Hospitals, US 1982-83 and 1983-84," *Mental Health Statistical Note*, no. 176 (September 1986).

not trained to handle their psychiatric problems. In fact, most nursing homes avoid offering mental health services, because, by doing so, they risk losing Medicaid, which is the major source of their funding. Medicaid specifically excludes coverage for people in Institutions for Mental Disease. This term is generally defined as an institution where more than 50 percent of the residents have a mental disease. Patients with organic mental disorders such as Alzheimer's disease are not counted toward the 50 percent ceiling.[7]

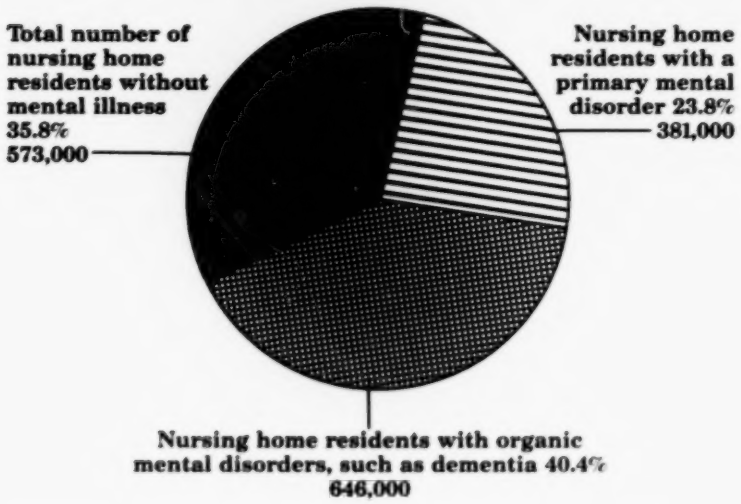
Nursing homes serve as a magnet for many patients released from state mental hospitals because federal reimbursement is available. The irony is that nursing homes are restricted by that same reimbursement authority from offering them any help for their primary problem. The result is that thousands of individuals suffering from mental illness who could live in the community if support services were available reside in highly staffed, restrictive institutional settings, at a greater cost to the taxpayer.

Community-Based Mental Health Programs. The community has replaced the hospital as the primary care setting for persons with serious mental illness. Today, approximately 77 percent of the individuals with serious mental illness live in the community.[8] In addition to discharged hospital patients, community programs are responsible for a new population of 18- to 35-year-olds who have spent little, if any time in institutions. Often called chronic young adults, these people are frequently substance abusers and more resistant to traditional treatment than formerly institutionalized patients.

Figure 3-1A.

Mentally Ill Nursing Home Residents as a Percentage of All Nursing Home Residents

(Total number of nursing home residents is 1.6 million)


Total number of nursing home residents without mental illness 35.8% 573,000
Nursing home residents with a primary mental disorder 23.8% 381,000
Nursing home residents with organic mental disorders, such as dementia 40.4% 646,000

Source: National Institute of Mental Health, 1988.

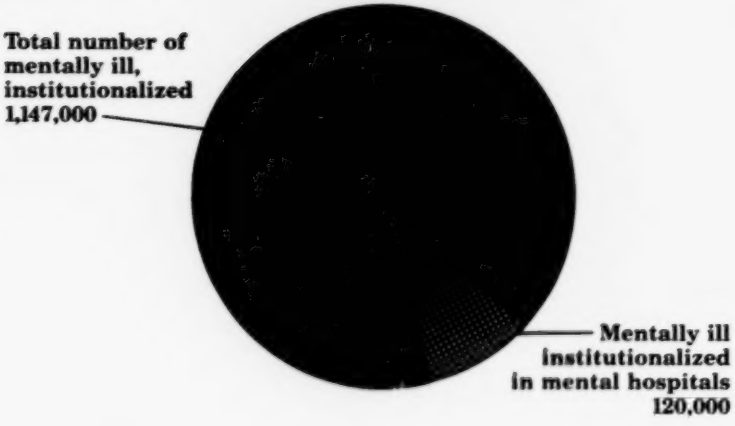
State mental health agencies provide for community-based care in the following ways:

- The state provides mental health services directly.
- The state contracts with vendors to provide mental health services.
- The state disperses money to local governmental bodies to provide or contract for mental health services.

In the past, community mental health centers were reluctant to provide services for individuals who were seriously mentally ill. However, recent trends indicate a clear shift in reorienting services to meet the needs of this population. A recent study indicated that community mental health centers and community-based programs are emphasizing delivery and service components to respond to the client's need, such as outreach programs and case management services. Community programs are also expanding residential and rehabilitation programs and increas-

Figure 3-1B.

Mentally Ill Nursing Home Residents as a Percentage of All Institutionalized Mentally Ill Persons



Source: National Institute of Mental Health, 1988.

ing crisis services to meet the varying delivery needs of those with mental illness."

Community Support Program (CSP) and Child and Adolescent Service System Program (CASSP). Initiated by the National Institute of Mental Health, the CSPs and CASSPs offer models for delivering community services to adults and children with long-term mental illness through small grants to states. These models attempt to provide the entire array of services, supports, and opportunities needed by persons with psychiatric disabilities to function in the community. The basic models for community support emphasize delivering services to the clients in natural settings within the community, rather than in mental health facilities. The models differ in the degree to which they provide services or to which they broker or arrange for services available from other community agencies and resources. However, all models emphasize coordination of services with other persons and agencies that relate to the client."

Criminal Justice System. Individuals with serious mental disabilities are arrested 20 percent more often than the normal

population.[11] Most of these people have committed only minor offenses such as vagrancy, destruction of property, trespassing, and disorderly conduct offenses that are more a manifestation of their illness than the result of criminal intent. Persons with serious mental illnesses account for 600,000 (approximately 10 percent) of the 6.2 million inmates in county and city jails. In large cities, that percentage rises from 20 to 35 percent.[12]

Lack of coordination among law enforcement officers, corrections personnel, and mental health providers often results in inappropriate placement of nuisance offenders. Because most jails do not have mental health professionals on staff, individuals with mental illnesses generally receive little mental health treatment in jail.

Other Public Agencies. In addition to mental health services provided by community programs, individuals with serious mental illness receive help from other federal, state, and local programs to help them live in the community. These programs include education, rehabilitation, welfare, food stamps, public assistance programs, social services, public housing programs, and income support programs such as Medicaid, Social Security Disability Insurance (SSDI), and Supplemental Security Income (SSI).

Delivery and Coordination Issues Confronting State Legislatures

States are faced with the challenge of pulling together disparate services for those with mental illness—funded and administered by different levels of government and operated through public and private mechanisms—into a system that makes sense. Following are some of the major issues states may confront as they create a coordinated, cost-effective system to care for persons with serious mental illnesses.

Issue: The Dollar Does Not Follow the Patient

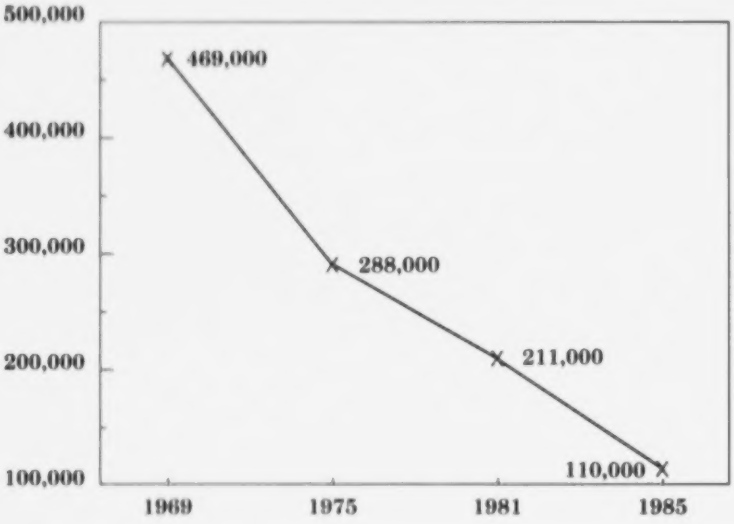
Structural system deficiencies have concentrated mental health funds on the state hospital, leaving little to pay for programs in the community, where a majority of the patients are. From 1955 to 1985, large state institutions reduced their patients by 80 percent,[13] but the dollar has not followed the patient to the community. Hospital staff have not followed the patients either. States found it difficult to confront powerful state employee unions and close hospital beds in institutions that served as a major source

of employment in the small communities where they were often built. Across the nation, high staff-patient ratios have contributed to the draining costs of running institutions that house a fraction of their former population. (See Figures 3-2A and 3-2B.) The result has been a discrepancy in where the money is and where the patients are. Even though 77 percent of persons with serious mental illnesses are in the community, more than two-thirds of the funding goes to the hospital.[11]

Community programs and state hospitals are stuck in a gridlock: Large inpatient institutions use up so much of the state mental health dollar that there is not enough left to give communities money to expand the community services that would keep patients out of the hospital and thus reduce the costs. The result is that more people with mental illness are cycling into and out of state hospitals, perpetuating the need for their continued support.

Figure 3-2A.

Average Daily Population
State and County Mental Hospitals



Source: *Mental Health, United States, 1987*, National Institute of Mental Health.

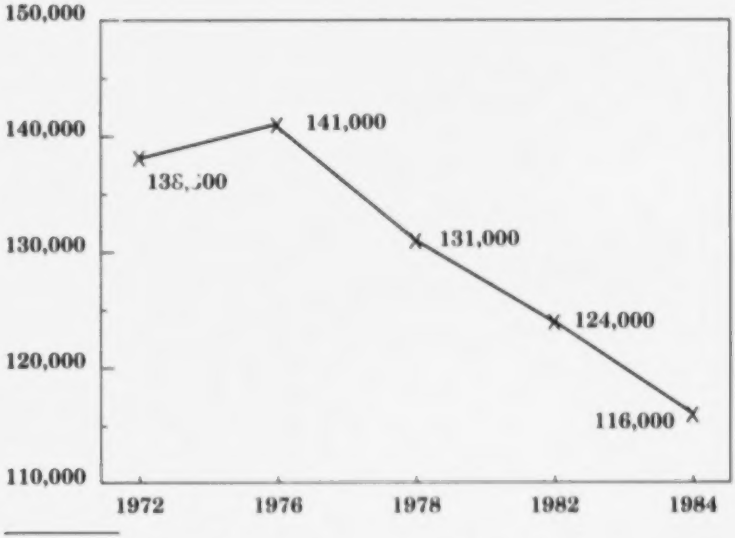
State Approaches: Develop a Single Point of Authority for Funding and Service Delivery

The way a system is organized and financed has a powerful effect on the coordination of services. Most states have a split funding structure: The state funds the hospital, and localities are responsible for community programs. This approach encourages community programs to send patients to the hospital, where the state will pay the bill. States can benefit by finding ways to reduce inpatient care and transfer the savings to community programs.

A single authority responsible for all mental health funds and service delivery can be instrumental in reducing the costs of inpatient care. The designated authority can be at the state, regional, local, or city level. If the designated authority must pay for inpatient care out of its own budget, it has an incentive to keep clients out of expensive hospital beds. Inpatient care can be

Figure 3-2B.

Patient Care Staff
State and County Mental Hospitals



Source: *Mental Health, United States, 1987*, National Institute of Mental Health.

reduced further by screening for admissions to the state hospital, reviewing lengths of stay, and expediting discharge planning.

The authority for funding and service delivery may vary, depending on a state's governmental structure, geography, and population. Some rural states may need to create multicounty liaisons for economies of scale and cost efficiencies. Some states, such as Wisconsin and Ohio, have invested service delivery and funding responsibility at the local level. Because of its small size, Rhode Island has been successful in consolidating funding and program authority in the state mental health agency. Cities may have a population large enough to require a single point of authority at the urban level. A five-year demonstration project, discussed below, will test the urban mental health authority concept in nine cities, with funding from the Robert Wood Johnson Foundation.

Wisconsin. In 1974, the Wisconsin legislature gave the counties full responsibility for mental health services, including control over both inpatient and outpatient funds. A Unified Service Board in each county administers all state and county mental health funds, providing greater local flexibility in services. Because counties pay for hospitalization, either by buying back beds from the state hospital or purchasing care in a private facility, they have a powerful incentive to keep patients out of the hospital. Wisconsin has achieved one of the lowest mental hospitalization rates in patients per 100,000 population, ranking 45th out of 50 states.[15] The most successful mental health program in Wisconsin is in Dane County, where about 83 percent of the mental health dollars go to community-based services. It should be noted that merely assigning funding and service responsibility to the counties will not guarantee cost-effective programs if the counties or designated authorities are not committed to developing housing and inpatient alternatives in the community.[16] In Wisconsin, counties that have not developed community alternatives to inpatient care spend as much as 70 percent of their budget on inpatient care.

Rhode Island. The state department of mental health is the single point of authority for funding and service delivery in Rhode Island. The executive director, who has line authority over the hospitals and the community mental health centers, can shift savings to those communities that are successful in reducing their inpatient use. As the reliance on hospitalization decreases, the communities will have more money to expand community services.[17]

Ohio. The public mental health system in Ohio includes 4,000 inpatient beds in 17 state hospitals, and 53 community mental health boards. The system will be restructured under a legislative initiative that was passed in 1988. The bill provides for merging clinical and funding authority at the local level. A lump sum will be allocated to each community board, including money to pur-

chase inpatient care. The community boards will then plan for patient days in the state hospital. If the community boards are successful in decreasing hospitalization, additional money will be available to spend on both state-run and privately provided community services. The boards, in turn, will be legally responsible for the care and treatment of each client.[18]

Foundation Demonstration Projects. With support from the Robert Wood Johnson Foundation, nine cities are creating local mental health authorities to consolidate planning, fiscal management, coordination, and evaluation of services for persons with serious mental illness. The authority will pool all funding from federal, state, and local governments, and then distribute the funds to mental health providers. In some cities, the existing county mental health board will become the central authority. In others, new private nonprofit corporations are being created to assume responsibility for individuals with serious mental illness. But in all cities, the authority will establish a single point of accountability and provide managerial flexibility to tailor resources in the mental health system to the clients' needs. The cities participating in the project are Austin, Texas; Baltimore, Maryland; Charlotte, North Carolina; Denver, Colorado; Honolulu, Hawaii; Philadelphia, Pennsylvania; and Toledo, Cincinnati and Columbus, Ohio.[19]

Issue: Passing the Buck on Difficult Populations

Some persons with mental illness, because of their special needs, do not fall clearly under the jurisdiction of the mental health agency. The lines of responsibility are not clearly drawn among the many agencies that could potentially contribute to treatment. As a result, many individuals who need treatment do not receive it. For example, agencies serving the growing number of substance abusers who suffer from mental illness often shift responsibility for the client back and forth. The mental health system cannot address the client's substance abuse problems, and the substance abuse agencies cannot offer relief for the mental illness. The problem of establishing who is responsible for this population is complicated by the fact that determining primary and secondary diagnosis is often difficult, if not impossible. The two problems are so interrelated that specialized treatment planning is required.

Other difficult-to-treat populations include individuals with mental illness who also happen to be homeless, children, elderly, and nuisance offenders arrested on charges related to their illness, such as disturbing the peace. Meeting the needs of these populations may involve coordinating care among the mental

health agency, social services, the public schools, the correctional system, vocational rehabilitation services, housing agencies, and substance abuse agencies, among others.

Public service systems often fail to meet the needs of these patients because the services are not divided in a way that will address their multiple problems, and little, if any, coordination exists between the agencies and programs that could help them. The agency staff, already overwhelmed by increasing caseloads and insufficient funds for their core populations, may be reluctant to provide treatment to those who do not clearly fall under their jurisdiction. Special approaches are needed for these difficult-to-treat populations.

State Approaches: Target Special Populations and Develop Cooperative Agreements

If the client does not fit the services, the services must be developed to fit the client. Often this involves the cooperation of many different agencies and programs. States coordinate services for the multiple needs of special populations through various approaches. Some states, such as Maine, have passed laws that require coordination among agencies to ensure care of targeted populations. Other states, such as Ohio, meet those needs through administrative, interagency agreements or "cluster groups" in which several state and/or local agencies get together for collaborative planning and, in some cases, pool resources to provide needed services. California, Florida, and New York targeted special needs populations, such as those with mental illness and in jail, homeless, or elderly. These states have developed programs to respond to their needs. Whatever the approach, each agency needs to know exactly what its responsibility is, with lines of authority clearly drawn.

Ohio. "Cluster groups" at the state and local level improve the delivery of services to multineed children and adolescents in Ohio. Representatives from six agencies meet regularly to develop jointly funded special programs for multiproblem youths. The agencies include the departments of mental health, mental retardation and developmental disabilities, youth services, health, human services, and education. The state cluster group has served as a model for equivalent groups developed at the local level.[20]

Maine. Following a 1977 legislative mandate, Maine's departments of human services, corrections, and mental health developed an interdepartmental, long-term policy for coordinating child and family services. The plan involves people at the local, regional, and state levels, from public and private agencies. An Inter-

Departmental Committee (IDC) is staffed by two people who coordinate all its activities. This cooperation at the state level is being reproduced on a regional basis by community mental health centers, regional family services offices, and public school systems. The result has been a reduction of service duplication, improvement in service delivery, and an expanded capability to identify and develop needed services, especially day treatment programs and residential home placements.[21]

New York. A recently convened New York task force recommended a statewide strategy to coordinate policy, service planning, and delivery for individuals suffering from mental illness and substance abuse.[22] One of the pioneering regional programs for this population will be run by New York's Rockland County Community Mental Health Center, the recipient of a state grant to focus on chronic young adults with drug and alcohol problems. Professionals will recruit clients through probation departments, schools, and store-front drop-in centers. A thorough family and individual evaluation will be conducted on each client, and needed services provided.[23]

Florida. This state has targeted the long-term needs of senior citizens with mental illness in the Geriatric Residential and Treatment System (GRTS). The program is open to people over 55 who are referred from the state mental hospital or to people in the community who are likely candidates for inpatient care. Participants enter a graduated five-level system of care intended to enable them to take on more responsibility for their lives. Necessary services are offered in one location, rather than leaving individuals with mental illness to piece together the necessary care from disparate service systems in multiple locations. At present, nine systems serve 67 counties. Funding for the program is provided by $11.2 million in state funds, with additional support from the communities.[24]

California. A 1985 legislative initiative requires a coordinated effort between the department of corrections and the state department of mental health to meet the needs of persons with serious mental illness who are in jails and prisons. The law requires the juvenile court to notify the local mental health agency upon determination that a child has a serious mental disorder. The department of corrections, with advice from the state department of mental health, must assess the need for intensive treatment of inmates with a history of serious mental illness. Convicted prisoners with mental disorders must be provided with the same outpatient services as patients in the state's forensic mental hospitals. Funds also have been allocated within six counties to deliver mental health treatment programs to inmates in county jails.[25]

New York. Under a proposal to create a corps of caseworkers, New York would be the first state to institute a statewide plan to bring mental health services to the homeless. Each mental health worker would be assigned no more than 10 clients. The workers would try to persuade their clients to come in for treatment, check to make sure they are taking their medication, and provide them with continuing support. Each caseworker could draw upon $4,000 per year in state funds for each client. The plan calls for an initial 500 caseworkers to serve 5,000 people statewide at a cost of $35 million annually. The plan will encourage caseworkers to take the service to the client, instead of expecting the client to come to the service.[26]

Issue: Lack of Continuity of Care

Continuity of care problems often arise when the client makes a transition. Ideally, there should be fluid movement from one type of service or program to another. However, because services are frequently funded and administered by different levels of government and operated by the public and private sector, this fluidity is rarely achieved. For example, in many parts of the country, the state mental hospital and the community programs run on parallel tracks, often with no linkages between them. The state funds and manages the mental hospital, while localities provide community services. Patients are sometimes released from the hospital without appropriate follow-up care, without a place to live, and without their entitled benefits. Left on their own, many are simply too disoriented, too volatile, or too isolated to find the help they need.

Even if a person with mental illness can figure out how to gain access to the community services he needs, the care he receives may be haphazard and uncoordinated. For example, he may live in a halfway house supervised by a residential director, participate in a day treatment program directed by a social worker, and depend on a psychiatrist for his medication. Neither the social worker, the residential director, nor the psychiatrist has ultimate responsibility for his welfare.

Even when the necessary components of care are available, barriers to accessibility may prevent programs from effectively serving consumers. The problem is further complicated by the number of agencies in addition to the mental health agency that provide support services to persons with serious mental illness. These include housing authorities, social security offices, vocational rehabilitation agencies, the educational system, the social service department, the Veterans Administration, the correctional system, Medicaid, and federal income support programs. A Ten-

nessee pilot study found that more than half of the funding for mental health services comes from departments other than the state mental health agency. The study identified 33 agencies within Tennessee that control these funds.[27] Table 3-2 shows a state-by-state breakdown of mental health expenditures by agencies in addition to the state mental health agency.

Seeking out the needed programs would be difficult enough for those in perfect health. It is almost impossible for a person with mental illness, who has a low tolerance to stress and inadequate functioning, to locate the necessary services. Yet if those with mental illness do not receive the services they need, their condition is likely to deteriorate until they are hospitalized again. Seventy percent of admissions to inpatient psychiatric facilities are readmissions,[28] suggesting that discharged patients are not receiving the necessary community care. Professionals call this the "revolving door syndrome." Because inpatient costs are so high, states are looking for ways to coordinate care so consumers will receive the community services that will prevent them from cycling into and out of the hospital.

State Approaches: Broker Care for Clients Moving Between Services

Case management is gaining popularity as a way of assuring service coordination for those with serious mental illness. A case manager is the human link between the client and the service agencies and serves as a guide through the complex array of programs, thus making services more accessible. The case manager may be responsible for assessing the client's needs, developing a comprehensive service plan, and arranging for services to be delivered. Case managers can be cost-efficient components of the delivery system by providing clients with the services they need to keep them out of the hospital. States such as Ohio and Oregon are using case management to make sure clients receive the services they need.

Other approaches that provide continuity of care include continuous treatment teams used by Vermont and Wisconsin. In this approach, clients are assigned to a team that maintains responsibility for services in all settings. Rhode Island uses liaison mechanisms between the hospital and community programs to smooth the patient's transition from the hospital into community programs.

Ohio. Three years ago, Ohio made state funds available for community mental health boards that presented plans for case management and supplied matching funds. Case managers are required to assist consumers in accessing all services and supports

they need, including mental health services, housing, employment, and health care. The case managers must be available 24 hours a day, 7 days a week to coordinate services for clients in emergencies. The case managers are responsible for the clients, regardless of where they are residing, whether in their own homes, in jail, on the street, or in a hospital. The case managers work with the hospital staff on discharge planning. If the newly admitted patient's job is in jeopardy, the case manager will work with the employer to see that the job is preserved. Before the patient is discharged, the case manager will line up housing and make sure the patient is signed up for federal income supports and state general relief assistance.

In Ohio's system, approximately 500 case managers serve about 30,000 mentally disabled people. The goal is to create a system average of one case manager for 35 clients. At present, some community mental health boards are pursuing case management programs more aggressively than others. Under new legislation that was passed in 1988, community mental health boards will be given responsibility for patients committed to the state hospital. This will give the boards incentives to expand their case management services to coordinate care and make sure the client receives the services necessary to prevent unnecessary hospitalization.[29]

Oregon. After expanding its civil commitment law, Oregon is developing a program to ensure that individuals with serious mental illness who are at risk of being committed to the state hospital receive services necessary to prevent hospitalization. The plan is based on the assumption that early intervention will result in reduced hospitalization, be less costly to the state, and create less disruption to the person and his family. Counties are given the names of residents who have been committed to the state hospital at least twice in the past three years. Each county is responsible for locating those at risk and providing them with case management services to make sure the clients receive the necessary treatment and care. The Oregon legislature appropriated $6 million in new funds for the 1987-89 biennium. Counties must submit plans and meet specified criteria to be eligible for the new money.[30]

Vermont and Wisconsin. In these two states, mentally ill clients are assigned to a continuous treatment team of mental health professionals who are responsible for services in all settings, including the state hospital. The team members do not attempt to provide all the needed services, but are responsible for seeing that needed services are obtained. This approach encourages greater accountability for difficult clients and limits disruption in the client's ties to professionals. Clients served by such teams

Table 3-2.

Selected State Agency Expenditures on Behalf of Mentally Ill Persons, by State Agency and Program: United States, FY 1983

State	Total Selected State Agency Expenditures	Medicaid Program	State Special Education	Other Agencies (Housing, Fringe, Administration)	Social Services	Vocational Rehabilitation	SMHA Capital Improvement Projects	Corrections/ Criminal Justice	Legal and Advocacy
Alabama	$ 6,593,342	NA	NA	NA	NA	NA	$ 5,428,971	$ 1,164,371	NA
Alaska	NA	NA	NA	NA	NA	NA	NA	NA	NA
Arizona	NA	NA	NA	NA	NA	NA	NA	NA	NA
Arkansas	23,787,108	$ 12,397,150	$ 1,282,880	$ 2,388,257	$ 4,782,291	$ 758,382	1,345,845	831,077	$ 1,226
California	99,841,772	99,041,772	NA	NA	NA	NA	NA	NA	NA
Colorado	6,737,726	NA	NA	341,097	5,682,336	714,293	NA	NA	NA
Connecticut	148,526,861	54,576,310	25,377,182	37,841,652	25,832,111	NA	4,245,120	452,031	202,455
Delaware	9,179,766	2,463,920	5,944,110	NA	NA	480,517	NA	204,780	86,439
Dist. of Columbia	NA	NA	NA	NA	NA	NA	NA	NA	NA
Florida	113,189,406	25,137,814	54,617,949	1,748,182	NA	7,279,408	20,688,894	3,717,159	NA
Georgia	87,796,798	42,385,089	33,989,523	3,817,553	1,096,614	615,528	4,622,491	1,270,000	NA
Guam	NA	NA	NA	NA	NA	NA	NA	NA	NA
Hawaii	8,146,317	NA	7,842,134	NA	NA	NA	NA	NA	304,183
Idaho	3,090,709	1,035,257	1,016,249	1,548	191,700	625,118	NA	175,400	45,437
Illinois	41,490,461	31,119,900	NA	NA	NA	2,233,961	600,000	7,200,000	336,600
Indiana	36,861,784	4,085,629	5,283,681	771,758	19,896,853	1,739,545	NA	5,084,318	NA
Iowa	64,450,771	24,843,580	20,299,763	212,330	13,560,493	703,297	323,908	4,494,477	12,923
Kansas	NA	NA	NA	NA	NA	NA	NA	NA	NA
Kentucky	NA	NA	NA	NA	NA	NA	NA	NA	NA
Louisiana	50,178,952	20,187,352	7,831,034	1,086,611	10,537,486	4,521,317	3,443,822	2,332,330	239,000
Maine	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maryland	111,564,573	47,809,864	NA	29,058,197	15,632,542	1,131,591	8,093,569	9,487,884	350,926
Massachusetts	30,548,511	18,257,867	707,867	NA	NA	1,861,949	NA	9,375,948	345,480
Michigan	60,767,377	44,305,000	7,843,377	NA	NA	6,733,000	1,881,000	NA	NA
Minnesota	NA	NA	NA	NA	NA	NA	NA	NA	NA

Mississippi	NA	NA	NA	NA	NA	NA	NA	NA	NA
Missouri	60,782,808	19,152,847	10,259,012	17,494,161	690,000	NA	12,188,791	620,086	377,911
Montana	8,564,448	1,871,906	1,210,307	74,868	4,702,659	223,164	184,182	242,408	54,954
Nebraska	NA	NA	NA	NA	NA	NA	NA	NA	NA
Nevada	419,947	NA	NA	NA	NA	111,246	NA	308,701	NA
New Hampshire	11,217,065	8,573,155	1,151,814	369,712	NA	560,343	257,315	196,545	108,181
New Jersey	50,084,346	38,546,316	NA	89,266	NA	4,684,424	3,744,101	1,538,883	1,481,356
New Mexico	NA	NA	NA	NA	NA	NA	NA	NA	NA
New York	403,124,000	NA	114,700,000	260,000,000	NA	28,000,000	NA	424,000	NA
North Carolina	27,383,669	3,203,446	8,896,700	1,158,382	NA	8,082,466	NA	6,042,675	NA
North Dakota	NA	NA	NA	NA	NA	NA	NA	NA	NA
Ohio	20,988,250	NA	18,414,645	1,173,605	NA	NA	1,400,000	NA	NA
Oklahoma	5,820,221	NA	NA	3,666,853	NA	NA	1,025,364	1,119,920	8,084
Oregon	12,132,853	4,867,151	311,318	817,600	5,028,615	343,250	87,549	547,370	130,000
Pennsylvania	NA	NA	NA	NA	NA	NA	NA	NA	NA
Puerto Rico	NA	NA	NA	NA	NA	NA	NA	NA	NA
Rhode Island	53,598,602	40,218,200	8,870,748	1,305,019	481,634	42,820	2,466,594	NA	213,587
South Carolina	29,781,699	NA	7,370,045	NA	NA	10,565,296	9,097,398	2,748,960	NA
South Dakota	949,708	NA	386,982	NA	NA	562,726	NA	NA	NA
Tennessee	73,944,130	47,228,773	1,544,020	11,789,645	3,519,315	2,236,632	2,125,387	4,430,118	1,070,240
Texas	69,946,378	18,800,349	25,802,228	2,082,365	4,448,103	11,442,241	6,988,499	357,593	25,000
Utah	20,948,027	4,010,602	10,764,126	284,433	4,068,270	585,045	NA	1,235,551	NA
Vermont	NA	NA	NA	NA	NA	NA	NA	NA	NA
Virgin Islands	NA	NA	NA	NA	NA	NA	NA	NA	NA
Virginia	49,272,909	NA	NA	9,061	42,212,442	NA	NA	7,051,406	NA
Washington	NA	NA	NA	NA	NA	NA	NA	NA	NA
West Virginia	6,427,288	3,035,449	NA	NA	NA	3,064,299	231,200	84,240	12,100
Wisconsin	16,659,046	NA	12,032,030	207,087	NA	2,091,575	NA	2,328,354	NA
Wyoming	NA	NA	NA	NA	NA	NA	NA	NA	NA
Totals	**$1,824,797,628**	**$617,954,098**	**$393,754,724**	**$377,789,242**	**$162,363,464**	**$101,993,433**	**$89,070,000**	**$76,466,585**	**$5,406,082**

Source: *Mental Health, United States, 1987*, National Institute of Mental Health.
NA: Data not available

have shown significant reduction in hospitalization and improvement in other quality-of-life indicators.[31]

Rhode Island. Community mental health centers in Rhode Island perform the admissions screening for the state hospital. As soon as a patient is admitted, a community liaison staff begins to work up a discharge plan with the client at the hospital. In five of the eight catchment areas, the community physician becomes the admitting physician to the state hospital. Because the physician is familiar with the risks and medication history of the patient, that physician is often able to expedite the client's discharge.[32]

Conclusion

States need to take a system-wide approach to coordinating mental health services into a rational, cost-effective system with clear roles and responsibilities for serving those with serious mental illness. Legislators will benefit by creating a strong framework on which to base future program decisions. Clients and their families benefit from reduced bureaucracy and easier access to the services they need. Taxpayers benefit from a cohesive, tightly run system that prevents duplication and unnecessary inpatient care. State approaches to coordinated services will differ as politics, needs, history, and resources differ. The ingredients for success are state leadership, rational planning, and commitment.

Notes

1. Ruth I. Freedman and Ann Moran, "Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization," *Medical Care* 22, no. 12 (supplement) (December 1984): s 25.

2. Steven Greene et al., "State and County Mental Hospitals, US 1982-83 and 1983-84," *Mental Health Statistical Note*, no. 176 (September 1986).

3. Bert Pepper and Hilary Ryglewicz, "Designing/Redesigning Public Policy for the Chronically Mentally Ill: We Need a New Bus!" *TIE Lines* 3, no. 2 (April 1986): 2.

4. Barbara J. Burns and Herbert C. Schulberg, "Organizing Psychiatric Care in General Hospitals to Meet Medical and Psychiatric Needs," *Administration in Mental Health* 13, no. 3 (Spring 1986): 181.

5. Testimony of Charles A. Kiesler, Dean of the College of Humanities and Social Sciences of Carnegie-Mellon University, before the Labor-Health and Human Services-Education Appropriations Subcommittee of the Appropriations Committee, United States Senate, November 19, 1984.

6. Ronald W. Manderscheid, National Institute of Mental Health, March 3, 1988: telephone interview.

7. Gail Toff and Leslie J. Scallet, "The Mentally Ill in Nursing Homes," *RIP: Report on Issues of Policy* (Washington, D.C.: Policy Resources Incorporated, June 1986): 3.

8. Ronald W. Manderscheid, March 3, 1988: telephone interview. This percentage does not include mentally ill nursing home residents with organic mental disorders, such as senility without psychosis.

9. Patrick Rogers, ed., *Trends and Innovations in Mental Health* (Arlington, Va.: Capitol Publications, Incorporated, 1986), p. 29.

10. Beth A. Stroul, *Models of Community Support Services: Approaches to Helping Persons with Long-Term Mental Illness* (Boston, Mass.: Center for Psychiatric Rehabilitation, August 1986), p. 8.

11. Rebecca T. Craig and Michelle Kissel, "The Mentally Ill Offender: Punishment or Treatment?" *State Legislative Report* 11, no. 13 (revised August 1987): 2.

12. Ibid.

13. Sarah Williams, ed., "Redirecting State Dollars to Build Community-Based Mental Health Systems," *Alpha Centerpiece: A Report on Health Policy Issues*, (October 1986): 1.

14. Theodore C. Lutterman et al., "Trends in Revenues and Expenditures of State Mental Health Agencies, Fiscal Years 1981, 1983, and 1985," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 34 (September/October 1987): 3

15. "State Hospitals and Their Role in the Continuum of Mental Health Care: State Models and Approaches" (Denver, Colo.: National Conference of State Legislatures, December 1987): 6.

16. Barbara Dickey and Howard H. Goldman, "Public Health Care for the Chronically Mentally Ill: Financing Operating Costs, Issues and Options for Local Leadership," *Administration in Mental Health* 14, no. 2 (Winter 1986): 75.

17. Danna Mauch, Executive Director, Rhode Island Division of Mental Health and Community Support Services, September 25, 1987: telephone interview.

18. Gail E. Toff, ed., "Ohio Considers Legislation to Decentralize Its Mental Health System," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 33 (July/August 1987): 1-3.

19. "The Robert Wood Johnson Foundation Program for the Chronically Mentally Ill" (Boston, Mass.: Massachusetts Mental Health Center, n.d.), pp. 1-8.

20. "Toward a Model Plan for a Comprehensive, Community-Based Mental Health System" (Washington, D.C.: U.S. Department of Health and Human Services, October 1987), p. 50.

21. E. Fuller Torrey and Sidney M. Wolfe, *Care of the Seriously Mentally Ill: A Rating of State Programs* (Washington, D.C.: Public Citizen Health Research Group, 1986), pp. 83-84.

22. Kathy Furlong-Norman, ed., "Young Adults With Psychiatric Disabilities," *Community Support Network News* 3, no. 2 (September 1986): 5.

23. Bert Pepper, Executive Director, Rockland County Community Mental Health Center, November 20, 1987: telephone interview.

24. "Mental Health Services for the Elderly: State Models and Approaches" (Denver, Colo.: National Conference of State Legislatures, May 1987): 1.

25. "Select Legislation Relating to the Mentally Ill Offender" (Denver, Colo.: National Conference of State Legislatures, July 1987): 5.

26. "Mental Health on the Street," *New York Times*, January 25, 1988, p. 22.

27. Margaret M. Hastings, *Financing Mental Health Services: Perspectives for the 1980s* (Rockville, Md.: National Institute of Mental Health, 1986), pp. 2-10.

28. Rebecca Craig, "Community Care for the Chronically Mentally Ill: Removing Barriers and Building Supports," *State Legislative Report* 11, no. 8 (revised May 1987): 2.

29. Rick Tully, Assistant Deputy Director for Program Support, Ohio Department of Mental Health, February 25, 1987: telephone interview.

30. Memo to Community Mental Health Program Directors from Dr. J. D. Bray, Assistant Administrator, Program Office for Mental or Emotional Disturbances, Salem, Oregon, July 7, 1987.

31. Patrick Rogers, ed., *Trends and Innovations in Mental Health*, p. 85.

32. Danna Mauch, September 25, 1987: telephone interview.

IV

Evaluating Mental Health Programs

Evaluation uses scientific methods of applied research to generate objective information about public policy and programs to aid in policy formation, program planning, and management. A well-done evaluation can help lawmakers answer the questions: Are we doing what we want to be doing? Can we do it better?

In this information age, policymakers need accurate, concise data to do their jobs. Good arguments are bolstered by quantitative facts, and quantitative facts are generated by evaluations. Evaluation is a kind of news—a way for legislators to keep up-to-date on mental health issues.

It is legitimate for legislators to ask for evaluation information. The science of evaluation provides many ways to address the problems posed by conducting research on mental health programs in applied settings. Legislators should no longer accept the allegation of some mental health providers that the results of mental health services can't be measured or compared.

This chapter describes the importance of evaluating mental health programs in the development of public policy and the many ways policymakers can use evaluations in the legislative process. In addition, questions used to ensure effective evaluations are outlined. Examples of states that have successfully incorporated statewide evaluations into the budget and management process of mental health systems are used to illustrate the importance of

evaluations to accountability. Finally, questions policymakers can ask to determine reliability of evaluations and performance measurements are discussed.

Evaluation and Public Policy

Generating objective information for evaluations is a technical activity, but the interpretation of information and its application to the development of programs is a political activity. Legislators have a kind of expertise evaluators do not have—knowing how to balance the different interests and needs. Legislators must fit the results of evaluations into a broader public policy context, and in doing so, they may encounter difficulties, including:

- Legislators must weigh the need for new mental health programs against the need for other programs, since they must also make funding decisions on police protection, road construction, education, and other issues.
- When drawing policy conclusions from evaluation results, legislators should consider the long-term effects. Programs at different stages of development will perform differently on evaluations. Often, approaches that appear to cost more in the short-term are, in fact, cost-effective in the long-term. For example, a program that shifts inpatient care from the state mental hospital to community-funded alternatives may cost more in the transition period, before the effects of decreased bed need are translated into actual savings. However, in the long-term, the program may result in direct and indirect cost savings.
- To determine program efficiency, legislators need to estimate at the margin. For example, how many more clients can be served if a program is given $5,000 more? How many fewer patients can be served if the amount is reduced? What person will be hired if funds are increased and how will this affect the program? In considering changes in funding, legislators need to ask: How many more or fewer people will be served if this much money is added or subtracted?
- When money is limited, legislators need to target resources where they will do the most good. The mental health system cannot be all things to all people. Legislators need to understand the difference between the

treatment of those with serious mental illness and the treatment of people with personal problems such as stress, troubled relationships, or eating disorders. In an era of scarce resources, lawmakers must be prepared to make hard policy choices that set priorities.

- Legislators need to take a broad look at all of the costs of providing care for persons with mental illness, recognizing that shifting costs from one agency to another does not save money in the long run. Reducing costs in one program may result in increasing costs in another. Not providing or eliminating programs for persons with mental illness may force those people into the state hospital, public shelters, or the criminal justice system. Since legislators are responsible for all budgets, they need to look at the big picture.

Legislative Uses of Evaluation

Evaluation can be an important tool to improve decisions about mental health program design, funding, operations, and management. In addition to providing information about specific programs, there are a number of general ways evaluations can help policymakers.[1]

Warning. Evaluations can send up the red flag on policy that is not working. For example, studies showing that persons with serious mental illness released from hospitals are not finding needed community services and are being forced back to the mental hospital can serve to highlight the need for policy change.

Guidance. Evaluation can offer guidance for program policy. Evaluations comparing several programs can point out which approach works better and under what conditions. For example, a study comparing the cost efficiency of two inpatient treatment approaches may show a lower cost per day in a custodial mental hospital, while the total cost per patient is much lower in a treatment-oriented hospital where patients are released sooner. This information can suggest directions for policy.

Rethinking. Some evaluations can help the policymaker approach a problem from a new angle, challenge previously held assumptions, or indicate new directions. For example, an evaluation of comprehensive community treatment for persons who are severely disturbed may document a significant reduction of social costs to the community through reduced emergency room use, fewer arrests and suicide attempts, and a reduced burden on

families. This new evidence may force a lawmaker who previously opposed new funding for community services to reconsider his position.

Education and Mobilization of Support. Policymakers can use results of evaluations to educate the public about the need for and effectiveness of programs and to help build winning coalitions to get behind a proposal. Evaluations can offer the hard evidence needed to sway opponents, win over the undecided, and reinforce the position of advocates. For example, if a policymaker is supporting a proposal to phase out the state mental hospital for all but the forensic population, a study showing that community services can provide all of the needed services for current inpatients could help the policymaker convince the local groups in his district that the proposal is workable.

The Legislator's Role in Evaluations

Legislatures in over 40 states have established some kind of mechanism to evaluate state programs. Although the nomenclature varies—program evaluation, performance auditing, program review, sunset—the mission is the same: to review, analyze, and assess how state agencies and programs have been working.

These evaluation units date from the late 1960s, when Hawaii and New York became the first state legislatures to set up evaluation units. Other states followed in the 1970s. Modeled after the U.S. General Accounting Office, these units are designed to provide legislators with objective, accurate, and independently generated information about state agencies and programs.

Nineteen legislatures have organized the program evaluation unit within an existing auditing agency. Financial and performance auditors usually work separately. Eleven state legislatures have created a separate administrative unit within the legislature that does only program evaluation. In 10 states, the evaluation function is part of the legislative fiscal agency, and in six state legislatures, it is part of a broader legislative service agency.

In Georgia and Hawaii, legislative auditors report to the entire legislature. Massachusetts uses a separate post-audit and oversight committee for each chamber. Most other legislatures use joint bipartisan committees to conduct program evaluations. Mississippi, Texas, and Virginia have no statutory requirements for bipartisan appointments, although minority party members can be appointed by the leaders. Some states require that members of the fiscal committees be appointed to the evaluation committee;

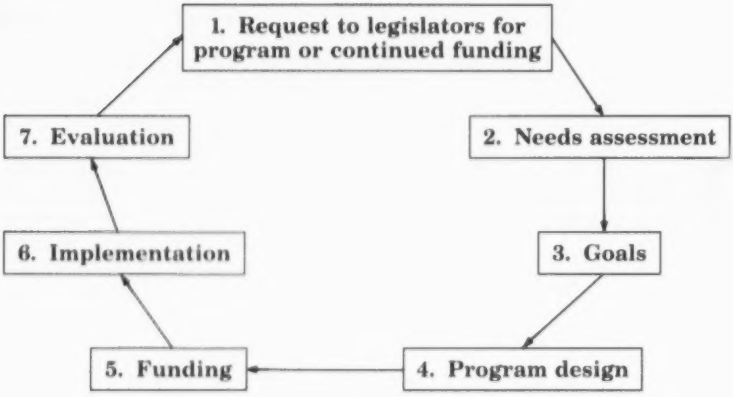
others appoint legislative leaders. Connecticut, Indiana, and Virginia include the chairs of the relevant standing committees when conducting evaluations of agencies or programs under their purview.[2]

Regardless of how the legislatures are organized and staffed to conduct evaluations, policymakers must initiate the evaluations and use the resulting data if evaluations are to be successful. A program evaluation, by itself, does not create cost savings or program improvements. These result from legislative action.

Evaluations are often focused on existing programs. However, legislators can also become involved in evaluations before a program is authorized. At this point, legislators can mandate that appropriate data be collected to allow a comparison of the program to similar programs, judge whether it has been successful, and decide if it should receive continued funding. Box 4-A outlines how this process ideally would work.

Box 4-A.

How Evaluation Helps Legislators Ensure Program Accountability



(1) The state mental health agency approaches the legislators with requests for a new program.
(2) Legislators authorize funds for a needs assessment.
(3) Based on the results of the needs assessment, the legislators set goals and establish standards and guidelines.
(4) The planning department designs a program to meet the goals and returns to the legislators for funding.

(5) Legislators adopt a law to fund the program, usually for several years, and write into the legislation specific evaluation requirements.
(6) The program is implemented.
(7) The program is evaluated.

Legislators can decide whether or not to continue funding the project by studying the evaluation results and determining if the program meets the need and fulfills its goals.

Making Evaluations Work

If legislators are going to base decisions on evaluations, they must have confidence in the results. Legislators should insist on input to the evaluation process to ensure the development of relevant and reliable data. At the same time, legislators need to give the evaluators enough autonomy to guarantee disinterested results. Whether working with staff evaluators or outside consultants, legislators should make sure that the evaluations are:

- *Focused.* Questions should be aimed at concrete, well-defined issues. The more focused the questions, the better the answers. Focusing is a legislator's responsibility because it involves setting priorities, determining goals, and deciding how the information will be used. Well-focused questions are the foundation of the evaluation. As legislators and evaluators interact to refine the questions, the evaluation begins to take form.
- *Timely.* Evaluations must fit into the legislative cycle. Legislators need data when the committee deliberations begin, not when the final vote is called. Late information, no matter how persuasive, will be of little value. Therefore, legislators need to make their information needs known early and request the information in specific formats to meet precise deliberation needs, such as an executive summary, a written report, an oral presentation, or a slide show.
- *Objective.* Evaluation results must be bipartisan. Arguments may arise over how to interpret the data, but no arguments should exist about the origin and reliability of the data. The evaluation results must be rigorous enough to withstand the scrutiny of outsiders and people of opposite viewpoints. While legislators

need to give the evaluators direction, if they become too involved in the methodology, they risk skewing the results. Evaluators need a certain amount of independence and autonomy to do their jobs well.

- *Usable.* Evaluations should generate information that is usable in the legislative process. Legislators deal with specific questions and must vote yes or no on specific bills and issues. Legislators need to make their needs clear to the evaluators early on. There is little reason for an evaluation to be conducted unless the results are used.

In the area of mental health, six basic questions can help legislators determine if a program is successful:

(1) What is the need for the program?

Needs assessments are important because types and amounts of mental illness vary across localities. Recent research indicates that mental illness varies dramatically, even in one state.[1] Areas with high rates of poverty, divorced families, and unemployment will have a sharply higher need for mental health services—sometimes as much as seven times the need.

Needs assessments should provide information on:

- The prevalence and incidence of different types of problems, by service area.
- The service need implications of the problems, in terms of types and quantities of service required.
- Service gaps—the types and amounts of services clients are currently receiving compared to what they ideally should be receiving.
- The ways in which problems and service needs are distributed across different target populations.
- Budgetary and other resource implications of closing service gaps.

Policymakers must have information on the types and amounts of mental health problems in communities and the service implications of these problems before they can establish policy and fund sensible programs.

(2) Who are the clients, what services do they need, and what services does the program offer them?

Demographic information—age, race, sex, education, income level, and the severity and nature of the mental disorder—is perhaps the easiest type of information to obtain. Determining services that specific clients need and use is more difficult. These evaluations are sometimes called pattern-of-use studies. A comparison of who uses the service with who needs the service will provide one measure of availability and accessibility of a mental health program. Studies can reveal the extent to which services are being used by high-risk populations, such as those who are mentally ill and substance abusers, children, homeless, or elderly, and how the program could address their needs more effectively.

(3) Who renders these services?

Information on staff activity is necessary to determine efficiency. Data can be collected on the percentage of the staff focusing on inpatient, outpatient, residential, education, prevention, and individual consultation; the types of clinicians who are providing certain kinds of service; and the mix of private versus public vendors. Data on staff-patient ratios, staff turnover, and service consistency can provide valuable information on how efficiently a program is operating.

(4) What is the funding source?

Knowing the percentage of the budget that is derived from state, federal or local government allocations, grants, third-party insurers, client payment, or federal reimbursements will allow program administrators and legislators to determine strategies to change the mix of revenues or target certain sources to maximize the revenues.

(5) What happens to the client as a result of the service?

Client outcome evaluations are necessary to determine a program's overall effectiveness. It does not matter how inexpensive or well-run a program is if

it does not have any effect on the client. Legislators who can provide documentation that a program is helping clients are better prepared when family members and advocates come to them with specific requests.

Outcome evaluations usually measure the client's ability to get along in daily life (buy groceries, write a check, take medication as directed, find a job); his social skills (making friends, getting along with family members); and psychiatric symptoms (hallucinations, phobias, anxiety, radical mood changes, and substance abuse). The information is gathered through interviews with clients and family members, questionnaires, or clinical observation. The client's satisfaction with the services can also be measured.

(6) What is the cost?

Business has always used operating data to evaluate its performance. In the retail business, the standard measure is dollars of sales per square foot of selling space. In the steel industry, the measure is tons of production per day. Health care has only recently focused on calculating costs. Now, hospital managers need to know the exact cost of an operation, from the price of x-ray and lab tests down to the costs of sweeping the floor. If costs can't be measured, they won't be managed. Mental health is following the lead of health care in determining operation costs.

Tracing the costs of mental health programs or services is a complex process guided by cost-accounting standards and procedures. Collecting comparable data annually is important to enable an accurate analysis of year-to-year costs. One method is to compute the cost per unit of service, which is defined as a single event: one day in the state psychiatric hospital, one visit to a psychiatrist, one group therapy session on a given day. The resources necessary to deliver the unit of service are computed by starting with the total program costs. For mental health programs, personnel costs are the greatest expense, although indirect costs, such as general administrative time and nonpersonnel expenses must be factored in. To determine unit costs, staff members

must accurately record the time they spend performing particular tasks during a given time period. Staff members' salaries are broken down to a rate per minute. Based on the proportionate amounts of time staff members in different salary ranges spend on specific services, costs for a unit of service can be computed.

Unit costs are not by themselves sufficient for conducting evaluations. You also need to examine costs such as episode cost and cost per outcome: how much it costs to maintain a discharged mental patient in the community or how much it costs to train and place a person with mental illness in a job. Legislators need to have an idea of the money required to accomplish a goal if they are to make responsible decisions.

The cost-effectiveness of programs can be measured by comparing cost outcomes. For example, an evaluation in California compared the cost-effectiveness of a hospital-based and a community-based adult day care program. The results indicated that both programs had significantly reduced inpatient admissions and length of stay. However, the community-based program had much lower costs, suggesting that policymakers consider community-based day care as an alternative to hospital-based programs.[4]

Since the federal government has gotten out of the business of funding evaluations in mental health programs, the responsibility has shifted to state legislators, who now must know which questions to ask to determine if a program is effective. Legislators who do not take this responsibility seriously are put in the position of making decisions based upon limited and, at times, biased information.

Evaluation Through Performance Measures

Evaluating programs on a regular basis through program performance measures, sometimes called performance indicators, is becoming popular. Performance measures are standardized to col-

lect objective, quantitative data on program operations. Some of the benefits of performance measures are:

- The program's evaluation is ongoing;
- Public relations are improved through systemic data that can be used to counter adverse publicity;
- Policymakers can appropriate funds based on program performance;
- Agencies can monitor services purchased from private vendors through established standards;
- States can develop mental health policy consistent with state priorities;
- Employees' morale is improved if they know their work is helping clients improve; and
- The public is confident that tax dollars are well spent if data indicate program effectiveness.

State Approaches

A number of states, including Colorado, New Jersey, and Pennsylvania have successfully employed performance measures to provide timely information on the mental health system.

Pennsylvania. Since 1979, Pennsylvania has used performance measures to reward the high performance of county mental health programs with increased funding. Counties must submit data in several categories, including responsiveness to need, revenue generation, unit costs for outpatient and partial hospitalization, state hospital admissions, and follow-up care.[5] Box 4-B lists the specific performance measures used in Pennsylvania.

In developing the system, Pennsylvania limited the number of performance measures and kept them simple to answer using existing data. New measures are tested annually and old ones are dropped in the ongoing process of refining and keeping the system flexible.

Performance measures are now an established part of budget allocations and influence the annual distribution of discretionary state funds to 43 county-level mental health programs. A county can lose or gain no more than 5 percent of its budget allocations based on performance measures.[6] Thus, while there are no big winners or losers, counties still have the incentive to score high on the performance measures, and a healthy competition exists.

A follow-up study revealed that the system had significantly improved the performance of the counties over a three-year

80

Box 4-B
Pennsylvania Performance Factors, FY 1982-1983

Distribution of Dollars: the deviation of a county's distribution of dollars from the average distribution. Its purpose is to encourage counties to provide a balance of types of services to patients.

Responsiveness to Need: the extent to which a county directs its resources into acute or aftercare services, given the relative need for services in those two areas. Its purpose is to reward counties that respond appropriately to needs.

Revenue Generation: the level of revenue generation in a variety of cost centers: medical assistance, client liability, and third-party insurance. Its purpose is to encourage counties to maximize the collection of revenues for services provided.

Services System Output: the total face-to-face service unit production per dollar spent in a given county. Its purpose is to encourage counties to purchase less costly and less restrictive service alternatives.

Unit Cost: the unit cost of services in outpatient and partial hospitalization services. Its purpose is to encourage clinical staff efficiency and the cost-effective provision of services.

State Mental Hospital Admissions: the level of less-than-60-day-admissions, readmissions, and emergency admissions to the state hospitals. Its purpose is to encourage counties to reduce use of state hospitals.

Aftercare Follow Along: the follow-up of county programs for patients discharged from state hospitals, including a measure of rate and timeliness of follow-up. Its purpose is to encourage the entry of all former state hospital patients into community treatment as rapidly as possible.

Report Submission: the timeliness of expenditure reports, annual plans, and community residential rehabilitation reports, and the completeness of the annual plan. Its purpose is to encourage the submission of timely and complete reports.

Source: *Mental Health Bulletin* No.500-81-02, "Performance and Need Factors for Fiscal Year 1982-83 Allocations," Rockville, Md.: National Institute of Mental Health, October 21, 1981, pp. 1-2.

81

period, although not all of the improvement can be directly attributable to the performance measures. During this period, mental hospital admissions were down 10 percent, and follow-up care for discharged hospital patients significantly improved. The discrepancy between well-funded and poorly funded programs decreased, although not as dramatically as county administrators would have liked. The state mental health agency noticed a significant improvement in the timeliness and quality of budgets and reports. In 1977-78, 25 percent of the reports were never submitted at all; those that were submitted were, on the average, 60 to 120 days late. For 1980-81, all but one budget request and year-end fiscal report were on time.[7] A majority of Pennsylvania's county mental health administrators have reported that the performance measurement system was a more objective way of budgeting and an improvement over the former, more subjective budgeting method.[8]

New Jersey. The New Jersey Division of Mental Health and Hospitals has developed a set of simple performance measures and related procedures to improve management decisions, help in the budget process, systemize reporting, and monitor community mental health programs. A task force from the sponsoring organizations, including the New Jersey Association of Mental Health Agencies, the New Jersey Association of Mental Health Administrators, the New Jersey Psychiatric Rehabilitation Association, and the Program Evaluation Action Committee, developed these measures. The task force identified the following four critical dimensions of performance:

(1) Appropriateness of service to high-risk target groups;
(2) Efficiency, including productivity and cost containment;
(3) Adequacy of program efforts to assure quality; and
(4) Effectiveness, in both client and system outcomes.

The data are obtained from six sources: the statewide client registry; the annual consolidated funding application; quarterly reports of client movement; expenditures of services provided; divisional data on hospitalization usage, screening, and assessed needs; and population data from the U.S. Census Bureau.

The measures were tested on eight agencies, representing large and small organizations in rural and urban areas. Because the newly developed systems did not have norms or standards against which to base performance, it was decided to suspend any consequences of performance until norms were developed.

The New Jersey performance management system, designed to promote sound management through explicit performance expectations, has developed slowly, as unforeseen problems

retarded its progress. The result has been a clearer understanding of the need for long-range planning.[9]

Colorado. Since 1978, Colorado has been measuring the mental health treatment outcome of its clients statewide. In the early 1970s, the state legislature decided that relying on expert testimony and individual mental health program evaluations was an unmanageable and unnecessarily complicated way to make funding decisions. The Legislative Joint Budget Committee began to hold the executive government more accountable to provide the information they needed to make decisions.

Responding to this mandate, the Colorado Division of Mental Health created new systems for collecting data on staffing, budgeting, and client characteristics. A task force was formed to add client outcome to the standard information collected. The task force solicited legislators' and administrators' input on test instruments, reliability and validity issues, training, costs, and implementation. After comparing different treatment outcome measures, the task force agreed to use a multidimensional checklist called the Colorado Client Assessment Record (CCAR), which clinicians complete upon a patient's admission and discharge. The checklist includes ratings of the client's personal behavior, thinking, social abilities, substance use, and ability to take care of himself.

The system goal was to determine if treatment had been effective. However, it soon became clear that the system had other uses. When the Colorado legislators requested that mental health dollars be limited to those clients most in need, the department could identify the most seriously ill clients from the CCAR data. This became the basis for determining eligibility for state mental health funds. Other uses for the CCAR include:

- Needs Assessments. Mental health centers interview samples of families using the CCAR questions to determine the need for services in the community.
- Cost-Effectiveness and Outcome Per Unit of Service. Since 1980, the division requires mental health centers to take a one percent sample of yearly admissions to determine the types of services received and to collect some billing information. With the admissions and other data from the CCAR, it is possible to compare outcome to units of service and to determine cost-effectiveness.
- Client Description and Bed Need. On one day of the year, the Division of Mental Health requires mental health centers to collect data on all active clients in inpatient, residential, and day treatment programs,

as well as on a 10-percent sample of outpatient clients. When supplemented by admissions information, these data provide a profile of all clients served. A model has been developed for estimating the numbers of clients appropriately and inappropriately served in different residential treatment settings. The model also estimates bed needs in various programs by identifying patients in inappropriate settings.[10]

In Colorado, when constituents ask state legislators if mental health services are effective, the legislators can answer, "Yes, and we have the data to prove it."

Conclusion

Two trends have converged in the United States to highlight the importance of evaluation to the state legislator. First, the new federalism has transferred the responsibility for evaluating and monitoring mental health programs to the state government. Second, advances in information-gathering and evaluation techniques in society have made it possible to generate sound data to make sound decisions. Business has long based decisions on data. Health care and mental health are increasingly expected to conform to good business practices that focus on costs, outcomes, and efficient management of resources bolstered by appropriate data.

In a political system that is sensitive to assessing and balancing conflicting claims and interests of a number of constituencies, evaluation can serve the role of an expert witness, providing the data that will help legislators make better decisions. In states such as Colorado, New Jersey, and Pennsylvania, evaluation has become an integral part of budgeting and management decisions. State legislators across the nation are realizing that evaluations are a valuable tool to help them do a better job.

Notes

1. Carol H. Weiss, "Evaluation for Decisions: Is Anybody There? Does Anybody Care?" (Plenary address for the meeting of the American Evaluation Association, Boston, Mass., October 16, 1987), p. 15.

2. Rich Jones, "Keeping an Eye on State Agencies," *State Legislatures* 13, no. 6 (July 1987): 20-21.

3. Dan L. Tweed and James A. Ciarlo, "Validating Statewide Indirect Needs Assessment Models: II—Construction and Testing of Statewide Social Indicator Models" (Paper presented at the Annual Meeting of the Evaluation Research Society, Toronto, Canada (October 1985).

4. Gerald Landsberg et al., eds., *Evaluation in Practice* (Rockville, Md.: National Institute of Mental Health, 1979), p. 192.

5. Charles Windle et al., eds., *Mental Health Program Performance Measurement* (Rockville Md.: National Institute of Mental Health, 1986), p. 41.

6. Trevor R. Hadley et al., "Impact of Performance Standards on a State Community Mental Health System," *Administration in Mental Health* 10, no. 3 (Spring 1983): 155-161.

7. Charles Windle, ed., *Program Performance Measurement: Demands, Technology, and Dangers* (Rockville, Md.: National Institute of Mental Health, 1984), p. 118.

8. Edna Kamis-Gould, "The New Jersey Performance Management System: A State System and Uses of Simple Measures," *Evaluation and Program Planning* 10 (1987).

9. Richard H. Ellis et al., "Statewide Treatment Outcome Assessment in Colorado: The Colorado Client Assessment Record (CCAR)," *Community Mental Health Journal* 20, no. 1 (Spring 1984): 79.

10. David C. Hoaglin et al., *Data for Decisions: Information Strategies for Policymakers* (Cambridge, Mass.: Abt Books, 1982), pp. 287-292.

V

Financing Mental Health Care with Federal Funds

Over the past 150 years, the responsibility for funding mental health services shifted among federal, state, and local governments. Local communities, and ultimately the state, recognized the needs of psychiatrically disabled persons and began providing public financing for institutional care. Private philanthropy and personal resources primarily funded community care of the aged and disabled until quite recently. Government programs provided few resources for community care, focusing instead on the development and maintenance of institutions.

Although the focus of treatment has changed in recent years from institutional care to community care, government funding sources have not shifted correspondingly. The majority of federal dollars are still spent for nursing homes and general hospitals, despite the fact that Medicaid funds can be used for noninstitutional care. However, federal financing trends, such as long-term care insurance and capitated care, could produce significant changes in the future reimbursement of mental health care.

Some states, faced with the insurmountable task of providing care for more with less, are obtaining relief through maximizing available federal resources. The following chapter explores federal

financing components that provide financial support for mental health care, including Medicare, Medicaid, income supports, and block grants. The second section examines current barriers to federal programs and recent efforts to address some of these barriers. In addition, specific strategies to maximize federal resources and state examples are provided.

Federal Sources of Funding

One of the major sources of funding for those with serious mental illness is federal supports provided under the Social Security Act, including Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicare, and Medicaid. The federal government provides 14 percent of the $8.3 billion expended annually on mental health services by state mental health agencies.[1] With the exception of state appropriations, Medicaid is the single largest source of expenditures for public psychiatric services in the United States, providing almost 10 percent of all state mental health expenditures.[2] In addition, federal block grants, especially Alcohol, Drug Abuse, and Mental Health block grants, provide services for the mentally ill and substance abusers in the community. (See Table 5-1.)

Federal supports are divided into several types of programs: entitlements, income supports, block grants, and other initiatives. These programs attempt to foster independence in the community through the provision of essential health and health-related services.[3]

Entitlement Programs

In an entitlement program, a specific set of services is provided through a voucher system or social insurance program. The consumer is restricted to a prescribed set of services and providers, such as Medicaid, Medicare, and prepaid health insurance programs.

Medicaid. Medicaid is a state-run medical assistance program operated under federal guidelines that require the provision of basic health and rehabilitation services to low-income families who meet certain categorical and financial criteria. Medicaid has become a major source of funds for many state mental health systems, despite its restricted use for those people between 21 and 65 years of age who are in institutions for mental disease. The program pays for more than 41 percent of all nursing home care, amounting to approximately $9 billion in federal funds.[4]

Table 5-2 contains reported Medicaid expenditures for 1983.

With the implementation of the Medicaid program, the federal government began assuming greater responsibility for the provision of long-term mental health care, and states were able to capture federal revenues from Medicaid by shifting patients from state hospitals to nursing homes. However, nursing home costs are paid by Medicaid only if the setting is not defined as an Institution for Mental Disease (IMD) by the Health Care Financing Administration (HCFA). A facility will be classified as an IMD if specialized psychiatric services are provided or if more than 50 percent of the patients have a nonorganic mental disease as a primary diagnosis.

As state and federal Medicaid costs have risen, policymakers have attempted to contain rising nursing home expenditures. Two Medicaid waiver programs, the home- and community-based services waiver (Section 2176) and the freedom-of-choice waiver (Section 2175), were established under the Omnibus Budget Reconciliation Act of 1981 to shift care from nursing homes. These waivers generally have been unavailable, although waivers recently were required to facilitate a large community mental health demonstration funded by the Robert Wood Johnson Foundation.[5]

The home- and community-based services waiver allows Medicaid dollars to be used, under certain conditions, to provide a broad range of home and community services to persons who otherwise would require care in an institutional setting. This waiver tends to promote community-based services as a substitute for hospital and nursing home care in targeted populations without increasing aggregate Medicaid expenditures. Colorado, Oregon, Rhode Island, and Vermont have had 2176 waivers approved for persons with serious mental illness.

The freedom-of-choice waiver permits states to restrict the service providers that a Medicaid recipient can see, if certain conditions are met. This waiver allows states more flexibility in managing Medicaid programs and promotes the development of cost-effective projects. Michigan, Utah, and Wisconsin obtained 2175 waivers to implement mental health case management arrangements.

Medicare. Medicare, while providing broad coverage for a variety of health services and products, is limited with respect to psychiatric care. Until the 1987 budget reconciliation, the Hospital Insurance section (Medicare Part A) provided coverage in general hospitals and limited care in freestanding psychiatric hospitals, and the Supplemental Medical Insurance (Medicare Part B) provided only $250 reimbursement for $500 of outpatient medical care. Increased benefits under Part B were established by statute in 1987 and include an increase in outpatient benefits to $1,100

Table 5-1.

Selected Federal Government Agency Expenditures on Behalf of Mentally Ill Persons, by Agency and State: United States, FY 1983

State	Total Federal Programs	Health Care Financing Administration		Special Education		U.S. HUD Housing for CMI
		SSDI	SSI	P.L. 94-142	P.L. 89-313	
Alabama	56,261,779	31,316,000	23,644,000	1,211,345	90,434	–
Alaska	2,674,642	1,339,000	1,233,000	58,290	44,352	–
Arizona	40,879,746	23,567,000	15,345,000	1,141,128	1,518	825,100
Arkansas	16,878,025	8,961,000	6,459,000	116,963	33,603	1,307,459
California	388,516,574	202,249,000	183,595,000	1,970,720	276,054	425,800
Colorado	30,227,560	15,179,000	11,450,000	1,751,870	159,600	1,687,090
Connecticut	22,425,262	14,223,000	5,128,000	2,815,182	259,080	–
Delaware	8,145,371	4,337,000	2,838,000	509,983	460,388	–
Dist. of Columbia	15,659,445	6,569,000	8,612,000	4,433	474,012	–
Florida	116,599,731	66,459,000	49,249,000	106,306	878,625	1,906,800
Georgia	87,224,816	47,931,000	35,309,000	3,631,008	353,808	–
Guam	43,746	NA	NA	12,246	31,500	–
Hawaii	14,213,198	7,271,000	6,830,000	76,760	35,438	–
Idaho	5,609,989	3,189,000	2,309,000	104,624	7,365	–
Illinois	195,253,160	97,584,000	87,021,000	4,475,744	6,172,416	–
Indiana	70,761,312	41,999,000	28,048,000	500,904	213,408	–
Iowa	34,683,809	21,717,000	11,234,000	1,097,656	88,913	546,240
Kansas	28,747,957	16,455,000	11,293,000	800,234	199,633	–
Kentucky	49,776,462	27,457,000	21,765,000	449,864	104,598	–
Louisiana	37,200,126	20,059,000	16,108,000	767,728	265,398	–

Maine	23,247,338	13,011,000	9,218,000	786,822	231,516	–
Maryland	40,613,716	21,302,000	18,144,000	723,576	444,140	–
Massachusetts	89,148,610	42,414,000	41,553,000	3,827,250	1,354,360	–
Michigan	222,208,364	125,744,000	91,562,000	4,270,062	632,302	–
Minnesota	66,193,415	40,309,000	24,525,000	1,322,400	37,015	–
Mississippi	45,542,943	25,352,000	19,631,000	81,800	5,643	472,500
Missouri	51,168,115	28,797,000	20,806,000	1,516,794	48,321	–
Montana	6,513,652	4,113,000	2,250,000	123,264	27,388	–
Nebraska	13,172,971	8,259,000	4,462,000	396,916	55,055	–
Nevada	9,372,227	5,230,000	3,953,000	127,988	61,239	–
New Hampshire	12,062,635	6,824,000	4,247,000	154,456	185,679	651,500
New Jersey	94,099,653	50,546,000	39,909,000	3,104,653	540,000	–
New Mexico	15,297,996	7,876,000	6,967,000	416,706	38,290	–
New York	239,106,025	121,566,000	104,265,000	7,233,640	4,134,685	1,906,700
North Carolina	49,900,659	30,582,000	17,968,000	1,088,115	262,544	–
North Dakota	3,527,765	2,296,000	1,174,000	56,448	1,317	–
Ohio	225,619,154	129,698,000	92,952,000	1,332,648	222,006	1,414,500
Oklahoma	30,500,837	18,018,000	11,606,000	203,193	41,344	632,300
Oregon	15,665,923	8,036,000	6,224,000	430,784	364,039	611,100
Pennsylvania	112,726,081	55,234,000	51,457,000	2,711,700	2,685,881	637,500
Puerto Rico	29,861,630	29,690,000	39,000	114,730	17,900	–
Rhode Island	16,551,788	9,790,000	6,498,000	225,828	37,960	–
South Carolina	41,129,854	22,642,000	17,263,000	1,210,266	14,588	–
South Dakota	5,671,694	3,603,000	1,996,000	51,985	20,709	–
Tennessee	45,830,558	24,874,000	19,475,000	478,828	193,930	808,800
Texas	84,469,974	45,412,000	34,233,000	3,194,356	1,129,118	501,500
Utah	16,204,333	8,227,000	5,793,000	2,130,282	54,051	–
Vermont	8,004,246	4,432,000	3,425,000	81,810	65,436	–
Virgin Islands	377,055	350,000	N/A	N/A	27,055	–
Virginia	51,969,343	28,605,000	21,138,000	1,355,532	225,811	645,000

Table 5-1.

(continued)

State	Total Federal Programs	Health Care Financing Administration		Special Education		U.S. HUD Housing for CMI
		SSDI	SSI	P.L. 94-142	P.L. 89-313	
Washington	60,251,158	28,797,000	27,421,000	818,154	127,204	3,087,800
West Virginia	19,055,248	10,555,000	8,220,000	255,528	24,720	–
Wisconsin	95,760,678	53,639,000	40,026,000	2,004,460	91,218	–
Wyoming	3,482,938	2,136,000	1,115,000	200,074	31,864	–
Totals	**$3,066,091,286**	**$1,675,820,000**	**$1,284,985,000**	**$63,634,126**	**$23,584,471**	**$18,067,689**

Source: *Mental Health, United States, 1987*, National Institute of Mental Health.
NA: Data not available
–: Quantity or percent zero

Table 5-2.

Reported Medicaid Expenditures: Fiscal Year 1983

Service Types	Dollars	Number of States Reporting
State-Operated Facilities	$ 939,273,968	50
Private Psychiatric Hospitals	144,304,315	30
General Hospital Psychiatry Program	235,550,629	17
Residential Programs	16,671,766	31
Ambulatory Care Programs	290,398,882	44
Long-Term Care	99,488,762	10
Other Services	129,164,542	20
Total Reported	**$1,854,852,794**	

Source: *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 34 (September/October 1987): p. 8.

for $2,200 of care; exemption from limits for the medical management of psychotropic medications; creation of mental health partial hospitalization services benefit; authorization of psychologist clinic services; and abolishment of the two-year waiting period for renewed disability eligibility.

Income Support Programs

The income support mechanism allows the government to transfer cash directly to the individual. The government determines eligibility requirements and the amount of funds to be provided. Income supports, such as SSI, SSDI, Aid to Families with Dependent Children (AFDC), and food stamps are helpful in assisting individuals to obtain nonmedical supports. In addition, SSI and SSDI are crucial in defraying the living expenses of residents in facilities not covered under Medicaid.

Food Stamps and Aid to Families with Dependent Children (AFDC). Food Stamps and AFDC provide persons experiencing mental illness with resources needed to survive in the community. The food stamp program is designed to supplement client cash income; residents in group living situations are now eligible for the resources. AFDC authorizes federal payments to states for providing aid and services to needy families and children.

Social Security Disability Insurance (SSDI). SSDI replaces wages lost due to premature retirement. SSDI is funded totally by the federal government from payroll deductions and is related to the disabled worker's employment history. SSDI provides approxi-

mately $1.7 billion to those with mental illness each year. The average monthly payment is $488 and the recipient has access to Medicare benefits after two years. The standards for disability due to mental impairment were changed in 1985, making SSDI more responsive to the needs of those with serious mental illness.[6]

Supplemental Security Income (SSI). SSI provides funds at subsistence levels to needy, aged, blind, and disabled persons who meet uniform, nationwide income and asset eligibility criteria. Individuals with mental illness receive approximately 23 percent of the $1.3 billion SSI payments each year. SSI payments are obtained from general revenues. The average benefit award is approximately $340 per month; states may elect to supplement this payment. SSI entitles the recipient to Medicaid benefits. The medical impairment criteria and standards for SSI are the same as for SSDI.[7]

Block Grants

Under the federal block grant programs, nine block grants were created to provide states with a variety of services. The Alcohol, Drug Abuse, and Mental Health and the Social Services block grants are the largest federal block grant programs that provide substantial resources for persons with mental illness.

Alcohol, Drug Abuse, and Mental Health (ADM) Block Grant. This block grant consolidated a number of federal assistance programs and is of special concern in financing mental health services. Operational funding of community mental health centers for specific services and coordination of mental health and health care are provided by the mental health portion of the grant. States must comply with a number of detailed requirements, and funds are allocated under a formula related to past spending.

Community Development Block Grant (CDBG). The Community Development block grant provides money through the Department of Housing and Urban Development to purchase, build, or rehabilitate property that would benefit low- and moderate-income persons. This is the federal government's principal program to help communities meet local housing and development needs. These funds also will cover certain services needed to support other block grant opportunities and may be used as seed money for other federal housing programs.

Social Services (Title XX) Block Grant. Title XX, the largest block grant to the states, is used primarily to prevent institutionalization by providing a range of community-based services. The Social Services block grant funds numerous community or social services. Portions of its $2.7 billion national appropriation have provided states with support services for persons with serious

mental illness. The portion of funds allocated for those with mental illness varies from state to state and is often difficult to determine because of insufficient data.

Other Federal Programs

The Department of Health and Human Services, including the National Institute of Mental Health (NIMH), the Department of Housing and Urban Development (HUD), and other federal agencies provide additional resources to support mental health services. These programs are provided through various mechanisms, including housing initiatives, demonstrations, and grants.

Federal Housing Initiatives. HUD administers most of the federal housing assistance and mortgage insurance programs. Other federal agencies that provide financial support in some form include the Department of Agriculture (Farmer's Home Administration), the Veterans' Administration (VA), and General Services Administration. The Section 202/8 Direct Loan Program for Elderly or Handicapped provides 100 percent direct federal loans for constructing, rehabilitating, or acquiring housing to serve the elderly or handicapped. HUD also offers a number of mortgage programs that are intended to stimulate the depressed housing industry by increasing and improving the means of financing mortgage loans. Other federal programs that provide housing aid include rental supplement or assistance programs.[8]

Demonstrations. In an effort to address the lack of coordination among mental health services in the community, NIMH created the Community Support Program (CSP). All fifty states have received CSP funds at one time to stimulate the development of community support systems for persons with long-term mental illness. The CSP represents the first federal initiative devoted exclusively to improving care of those with serious mental illness in the community. In addition, Congress mandated the Child and Adolescent Service System Program (CASSP) in 1984 to improve service delivery and to develop a comprehensive, coordinated system of care for children and adolescents with serious mental illness. In recent years, Congress funded additional initiatives affecting people with mental illness, such as the Homeless Assistance Act and the Mental Health Planning Act, which are discussed later in this chapter.

Other. A number of other federal programs and laws provide major funding sources for mental health:

- The VA provides exhaustive inpatient, outpatient, and long-term care services for persons experiencing mental health problems. These services include acute psy-

chiatric care provided by more than three-quarters of the VA hospitals and long-term care purchased from community providers.

- The insurance program for the Department of Defense, the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), is a substantial provider of mental health benefits, including inpatient and outpatient treatment, hospitalization, and care in residential treatment facilities. This insurance program serves about 9.3 million military beneficiaries, their dependents, retirees, or dependents of retirees.
- The Education for all Handicapped Children Act of 1975 provides an entitlement for all handicapped children to supplement basic local and state funding of educational programs for handicapped children.
- The Rehabilitation Act of 1973 authorizes over a billion dollars in federal support for training and placing mentally and physically handicapped persons in employment.
- The Older Americans Act, the Job Training Partnership Act, the Elementary and Secondary Education Act, and the Vocational Education Act also provide funds for mental health.

Programmatic Barriers to Federal Programs

Although federal programs such as Medicaid, SSDI, and SSI are vital to the support of those with serious mental illness, various aspects of these programs make it difficult for this population to benefit from these funds. Obstacles include the following:[9]

- The application and eligibility process for federal programs is complex, preventing some people with mental illness from applying for assistance. Application procedures often require long waiting periods, and the disability certification process can be lengthy and complicated.
- The level of payment for SSI recipients is sharply reduced when an individual receives support or in-kind benefits from a household provider. This policy tends to undermine the support many persons with serious mental illness receive from their families. There is no

penalty for family support of SSDI recipients.

- If income exceeds $300 per month, benefits may be reduced or discontinued. Because the functional capacity of a person suffering from mental illness may fluctuate, short-term employment would jeopardize the individual's access to continued benefits during periods of deterioration.
- Reimbursement for services provided in an outpatient setting often is restricted by the setting and the professional providing the service. In addition, rigid definitions for reimbursable services do not include imperative services needed by those with mental illness, including day treatment, partial care, and subacute treatment.
- Funding programs encourage institutional treatment of mental health problems. This often results in the inappropriate placement of patients in intermediate or skilled nursing facilities rather than less restrictive outpatient settings. Additionally, limitations on treatment in inpatient psychiatric facilities create incentives to send patients to a general hospital, which, in many cases, is unable to adequately address the long-term needs of chronic patients.

In recent years, the Social Security Administration (SSA) has attempted to address some of these barriers to federal benefit programs. Some of these efforts include the following:[10]

- A special category of the work incentive provisions of SSI permits the individual to retain entitlements to Medicaid, even though SSI is reduced as income increases.
- A recent initiative, Program for Achieving Self Support (PASS), allows disabled SSI recipients to set aside income for a specific work goal, such as education, training, or the purchase of specific tools. Applicants must submit a work plan and, if approved, are exempt from the income limits for the duration of the plan.
- For SSDI recipients, payments are maintained at current levels during the trial work period even if there are earnings or other income. For 15 months after the trial period ends, SSDI payments can supplement work earnings if they slip below $300 a month. Even after SSDI ends, Medicare continues for two years.
- SSI recipients who are temporarily institutionalized now can maintain full benefits if the stay does not

exceed three months and the individual maintains a living arrangement in the community.

Strategies to Maximize Federal Resources

In today's time of ever-tightening budgets, state legislators demonstrate increased interest in strategies that increase or maintain services by changing the way funds are used, rather than by appropriating more money. The ability to use existing state dollars to increase the overall funding pool is important, particularly if done in a concerted effort to focus on the most-in-need groups. By leveraging available federal funds, states are able to maximize further their mental health dollars.

Without changing regulations, federal funding of services to individuals with serious mental illness can be maximized four ways: by increasing the number of eligible individuals through identifying and enrolling them in the appropriate programs; by increasing the number of providers who are certified to be reimbursed for the services they deliver; by reorganizing the way mental health services are delivered; and by understanding federal regulations.[11] States also can capture additional dollars by applying for available federal grants, demonstrations, or initiatives.

Strategy: Increase the Number of Eligible Individuals

Some states have developed special outreach programs to identify seriously mentally ill individuals eligible for, but not receiving, SSI, SSDI, and related benefits. Outreach methods include helping those who are mentally ill and homeless and who reside in shelters to file applications through the local social security office and developing programs that determine on-site eligibility at homeless shelters or other facilities at which seriously mentally ill people congregate.

Pennsylvania. The General Assembly of Pennsylvania authorized the Disability Advocacy Program (DAP) to assist disabled people receiving state welfare aid to obtain benefits such as SSI, SSDI, and Medicaid. By doing this, the state is able to shift some of the costs of supporting the disabled to the federal government. The DAP program performs the following functions:

- Income maintenance workers screen welfare clients and new applicants to determine if they match a profile of persons likely to be eligible for SSDI and SSI.

Individuals then are referred to the disability advocacy workers in county assistance offices.

- Advocacy workers assess a client's ability to tackle the federal disability benefits application process and develop a comprehensive social, medical, and work history for the client. Workers also may act as the client's representative with the SSA during the application process.
- A medical review team reviews applicants' histories to determine disability under federal regulations. A client-tracking system also is maintained, and consultation is held with state medical review teams to determine if an appeal is warranted when an applicant is denied.
- Mental health clinicians from the state Mental Health Department document the disability of individuals in their programs. Clinicians also may be asked to encourage their clients to apply for disability benefits.

For those who gain eligibility for SSI and SSDI, benefits can be doubled from $150-$185 per month under state-run general assistance to more than $350 under SSI or SSDI. The state saves about $1,740 per year for each person on general assistance who becomes eligible for federal disability benefits. The state also saves almost $1,400 annually per person when the Disability Advocacy Program documents a person's Medicaid eligibility.[12]

Ohio. Similar to the Pennsylvania initiative, Ohio's focus has been on improving access to SSDI, SSI, and other federal entitlement benefits. Ohio implemented a variety of model programs to expedite the SSI/SSDI application and disability determination process. Most of the programs provide for case management involvement, intensive cross-training of case managers and Bureau of Disability Determination (BDD) staff, use of SSA teleclaims procedures, and flagging of cases at BDD for quick turnaround. These approaches have resulted in reducing the average processing time from more than 120 days to less than 45 days.[13]

Strategy: Increase Certified Providers

While certain types of programs are, by definition, not reimbursable by Medicare, Medicaid, or third-party payors, other services may be, if provided in a certified setting. Although the costs of raising the standards of care in state hospitals and mental health agencies to meet certification standards may outweigh the benefits, the potential for federal revenue generation should be reviewed carefully for every agency delivering services to individu-

als with serious mental illness. An additional benefit to clients is that the standard of care is raised and monitored to ensure that it does not drop below some minimal level.

Massachusetts. The state passed a capital outlay bill in 1987 that provides $207 million to improve and expand the state's mental hospitals. Following a thorough analysis of the staffing levels necessary to meet Joint Commission on Accreditation of Health Organizations (JCAHO) standards, Massachusetts developed a plan that will provide a full range of activity, treatment, and day services. These services will be supported by adequate medical records, dietary services, housekeeping, and building maintenance. The request includes:

- Funding for 422 skilled active treatment staff;
- Funding for 80 physicians and psychiatrists; and
- Funding for 122 maintenance, clerical, and administrative personnel.[14]

Strategy: Reorganize the Delivery of Services

States may reorganize to create a total care system for those with mental illness and, at the same time, expand federal participation under Medicaid to fund mental health services. Under current Medicaid law and regulations, an optional or preferred range of community mental health services may be developed to enhance services for people with serious mental illness in the community. Such a package could include the following:[15]

- Case management services for those with serious mental illness, which are allowed under the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA);
- Rehabilitation services recommended by a physician, which permit states to offer a variety of treatment interventions to persons with severe and disabling mental illness;
- Clinic options, which allow community mental health centers to bill Medicaid for services delivered to Medicaid-eligible clients and permit a range of ambulatory care, such as outpatient and partial hospitalization services; and
- Inpatient services in general hospitals, which are utilized frequently by some states, but often are not well integrated with other forms of community-based mental health service.

A second strategy that states could implement to increase Medicaid funding is the use of a "soft match." This refers to the practice of reallocating state funds from an existing fully funded state or local program and utilizing them as match funds for new or expanded Medicaid services. Most states using this approach reallocated funds from services that are similar to the new or expanded Medicaid services. Some states expand Medicaid options for mental health with no increase in state expenditures; this occurs if existing community mental health services, such as outpatient care, are paid for by 100 percent state funds.[16]

Colorado. A major feature of the Medicaid clinic option program in Colorado is that it is self-funded; any general funds necessary to match Medicaid were supplied from existing appropriations. Services were refinanced each year by the state Mental Health Division, transferring the amount of general funds necessary to match the Medicaid bill to the Medicaid agency. The clinic option is the only self-funded Medicaid program in Colorado.

The state has funded a range of mental health services through the Medicaid clinic option, including:

- Case management;
- Outpatient services—less intensive and of shorter duration per treatment episode than partial care;
- Partial care—more intensive than outpatient services and usually involving two or more hours of treatment activity every day;
- 24-hour emergency (crisis) care; and
- Full care—more intensive than partial care and involving a full day of care.

Prior to the implementation of the clinic option within the state, a total of $400,000 was expended for all Medicaid mental health services. In 1986, the state spent $16 million on Medicaid, of which $8 million was new federal money for services to those with mental illness. The percentage of clients served by the mental health centers who fit the definition of mental illness is approximately 85 percent of the total clients served, up from about 60 percent prior to the implementation of the clinic option.[17]

Oregon. Oregon was the first state in the nation to offer alternatives to long-term care placement under its 1981 home- and community-based services waiver. A new waiver was granted in 1985 to replace the waiver that expired in 1984. The program attempted to prevent inappropriate admissions of mentally and emotionally disturbed individuals to nursing facilities and promoted the transfer of individuals from institutions to community-

based settings. Three types of residential settings are used:

- RCF-MED provides 24-hour supervision and care for adults who cannot live independently in the community.
- RCF-T facilities provide 24-hour supervision for adults who are very dependent and have not demonstrated the capacity to benefit from training.
- Adult foster homes provide crisis intervention, living-skill training, and other needed support services for adults able to reside in the community with assistance.

State officials indicate that the program consistently provided services on a cost-effective basis. The program serves approximately 800 to 900 people per year at approximately $1.9 million in year two and $1.4 million in year three. The state estimates that these costs are a significant savings over the intermediate care facility rate of $40 per day.[18]

Ohio. The state of Ohio has implemented several initiatives that maximize federal dollars for community mental health services. Ohio targets $700,000 in mental health subsidy funding each year to be used as a match for vocational rehabilitation dollars for persons with severe mental illness; this $700,000 generates $2.8 million in federal funds. An automated tracking system and state interdepartmental and local agreements assure compliance in targeting the funds. In addition, state dollars allocated for Medicaid-covered mental health services are used to meet the state matching requirement, which in Ohio is 41.7 percent. The program has grown from $2 million in 1982 to $23 million in FY 1988.[19]

Strategy: Explore Regulation Fine Print

Studying regulatory changes and "fine print" may lead to increased funding for certain categories of patients. The federal government recently refined eligibility requirements and service restrictions in an effort to eliminate barriers to federal programs that are vital to those with mental illness. A careful study of all changes in federal programs will ensure that available resources are being used effectively. Some of these recent changes are:

- Recipients of Medicaid or SSI formerly were required to have a permanent address. A recent change requires only that recipients be residents of the state in which the application is made.
- Recent changes regarding the reimbursement for nonhospital treatment of Alzheimer's disease include

the removal of routine office visits for medical monitoring and treatment from the $250 annual cap on mental health outpatient services.

- Medicare regulations limit reimbursement for physician office visits to $250, and outpatient treatment by nonphysicians is not covered at all, except for psychological testing. However, a benefit provided under Part A of Medicare allows for some hospital-based outpatient clinic treatment of those with serious mental illness to be 80 percent reimbursed, with no dollar or cost limits.
- Home- and community-based services waivers, which were limited in the past to those in danger of imminent hospitalization, now can be used for those at risk of hospitalization, if community services are insufficient for care or treatment. However, no new home- and community-based services waivers have been granted by HCFA for mental health in recent years.
- Case management services now are reimbursable without a 2176 or home- and community-based services waiver or the need to replicate case management on a statewide basis. Those individuals with serious mental illness are eligible for these services.
- For the nine cities receiving Robert Wood Johnson Foundation (RWJ) monies under the Program for the Chronically Mentally Ill, waivers can be submitted to the federal government to apply for federal reimbursement of services such as habilitation, day treatment, partial care, residential services, psychosocial rehabilitation, and other services as approved.

Strategy: Capture Existing Grant and Housing Resources

In addition to maximizing federal reimbursement through the four methods previously outlined, resources also are available through NIMH, federal housing programs, and various other federal programs. These resources can provide states with financial incentives to work on a variety of specific mental health issues and finance a substantial portion of residential programs.

Newly funded, time-limited federal resources, some of which do not require a state match, currently include the following opportunities:[20]

- *State Mental Health Planning Grants (P.L. 99-660).* In order to continue eligibility for block grants, each

state must complete a state plan by 1991 or risk losing a portion of the block grant. NIMH, U.S. Department of Health and Human Services, will develop a model mental health plan for interested states and will award $82,200 for each state to devise its own plan.

- *Chronically Mentally Ill Demonstration Project.* Over $4.5 million is available for a number of three-year projects for mentally ill persons who are homeless through NIMH. Only one project will be funded within each state. The project does not have to be a statewide demonstration, and the average award within each state is $125,000.
- *Geriatric Training.* Grants are available through NIMH to support training of postgraduate physicians and retraining of practicing physicians in geriatric medicine, including psychiatry.
- *Vocational Rehabilitation.* The federal Vocational Rehabilitation Act was reauthorized and expanded for the next five years. Twenty-five million dollars was provided in FY 1987 to assist states in developing collaborative programs for supported employment.
- *Housing Demonstration Program.* The U.S. Department of Housing and Urban Development (HUD) is providing funds to develop transient housing for the homeless and permanent housing for handicapped persons. Both programs target persons with mental disabilities. There will be a national competition for the funds, and states must provide a 50 percent matching fund.
- *Homeless Assistance.* Congress appropriated $355 million for fiscal year 1987-88 to provide emergency and long-term approaches for housing homeless people.

Some states have made good use of federal funds to develop housing for the disabled, although government funding for low-income housing development and rental subsidies has been dramatically reduced in recent years. These states financed substantial portions of their residential programs through federal resources, such as HUD Section 8 and 202, Community Development Block Grants, and Rental Rehabilitation.

Colorado. Colorado formed the Community Housing and Services (CHS) program in 1977 to provide community-based alternatives for its disabled population. This program is the only statewide Public Housing Authority administered through an existing human service agency. CHS began with 80 Section 8 existing certificates provided through HUD. The program has

grown to almost 1,000 Section 8 certificates and vouchers in the past 10 years.

Two new components recently have been added to the traditional Section 8 program. Denver was selected as one of nine cities to receive a grant from RWJ and HUD for the care of those with serious mental illness, part of which included 125 Section 8 certificates. The second component is a new housing alternative offered by HUD that uses Single Room Occupancy (SRO) units to house the disabled. Section 8 certificates and vouchers fund 26 SROs in six localities.[21]

Nebraska. Nebraska uses two federal housing loan programs, HUD-202 and Farmer's Home Administration (FmHA), to finance housing programs for persons with mental illness in the community. An innovative HUD-202 funding approach involves the distribution of housing units over several service areas rather than one large project in one area. The Greater Nebraska Independent Housing Project includes construction of 37 units of independent living for persons with serious mental illness in six counties. Final closing for this 202 program is expected in the fall of 1988. FmHA loans built a new clubhouse under the "Community Facilities Program" category and also financed a 20-unit apartment complex adjacent to the clubhouse through a private, nonprofit corporation.[22]

Conclusion

Multiple federal funding sources provide individuals with serious mental illness support for housing, mental health and medical care, social and rehabilitation services, and basic minimum maintenance needs. Recent changes by Congress have created opportunities for providing or maintaining services to those with mental illness through use of federal dollars. With increasing demands on current services and potential shortfalls in governmental funding, states can benefit from strategies that will expand existing and explore potential sources of funding.

Notes

1. Theodore Lutterman et al., "Trends in Revenues and Expenditures of State Mental Health Agencies Fiscal Year 1981, 1983, 1985," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 34 (September/October 1987): 5.
2. Ibid., p. 5.

3. The following section is drawn primarily from Barbara Dickey and Howard Goldman's "Public Care for the Chronically Mentally Ill: Financing Operating Costs, Issues and Options for Local Leadership," *Administration in Mental Health* 14, no. 2 (Winter 1986): 63-77.

4. U.S. Congress, House, Committee on Government Operations, *From Back Wards to Back Streets: The Failure of the Federal Government in Providing Services for the Mentally Ill*, 100th Cong., 2d sess., 30 March 1988, p. 10.

5. More detailed information on Medicaid waivers for mental health services can be found in Gail E. Toff and Leslie J. Scallet's "The Medicaid Waiver and Its Use in Financing Mental Health and Related Services in the Community," *RIP: Report on Issues of Policy* (Washington, D.C.: Policy Resources Incorporated, April 1986).

6. U.S. Congress, House, Committee on Government Operations, *From Back Wards to Back Streets: The Failure of the Federal Government in Providing Services for the Mentally Ill*, p. 9.

7. Ibid.

8. Additional information on federal housing initiatives can be found in Frances L. Randolph, Bob Laux and Paul J. Carling's *In Search of Housing: Creative Approaches to Financing Integrated Housing* (Burlington, Vt.: Center for Change Through Housing and Community Support, University of Vermont, 1987).

9. Ruth I. Freeman and Ann Moran, "Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization," *Medical Care* 22, no. 12 (Supplement) (December 1984): s37-s38.

10. Dickey and Goldman, "Public Care for the Chronically Mentally Ill: Financing Operating Costs, Issues and Options for Local Leadership."

11. Ibid., pp. 11-13.

12. Patrick Rogers, ed., *Trends and Innovations in Mental Health* (Arlington, Va.: Capitol Publications Incorporated, 1986), p. 8.

13. Rick Tully, "Current Innovative Funding Strategies in Ohio" (Columbus, Ohio: Department of Mental Health, n.d).

14. Commonwealth of Massachusetts, *A Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons* (Boston: Commonwealth of Massachusetts, December 1985), p. 24.

15. Noel A. Mazade and Richard C. Surles, *Utilization of Medicaid Reimbursement for Community-Based Mental Health Services* (Rockville, Md: National Institute of Mental Health, Division of Education and Services System Liaison, January 1987), pp. 14-17.

16. Ibid., pp. 20-21.

17. Bruce Berger, "Colorado's Experience in Financing Community Mental Health Services Under Medicaid," Gail E. Toff, ed., *Financing Mental Health Services Under Medicaid: Proceedings from a Roundtable on Mental Health Policy Issues* (Washington, D.C.: Intergovernmental Health Policy Project, December 1986), pp. 17-22.

18. Toff and Scallet, "The Medicaid Waiver and Its Use in Financing Mental Health and Related Services in the Community," pp. 9-10.

19. Tully, "Current Innovative Funding Strategies in Ohio."

20. Rebecca T. Craig and Michelle Kissell, *1986-1987 Mental Health Issues and Select State Responses* (Denver, Colo.: National Conference of State Legislatures, August 1987), p. 17.

21. Norleen Palmer, *A New Lease on Life: Housing the Mentally and Developmentally Disabled* (Denver, Colo.: Colorado Department of Institutions, Community Housing and Services, revised May 1987).

22. Priscilla Henkelmann, "Innovations in Financing Community Mental Health for Persons with Severe and Persistent Mental Illness in Nebraska" (Lincoln, Nebr.: Nebraska Department of Public Institutions, November 3, 1987).

VI

Financing Mental Health Care with State, Local, and Private Funds

States are the centerpiece for the mental health service system. Not only do they provide the vast majority of the funds to the state mental health agencies, they also oversee local governments and most private resources for mental health funding. States develop laws that regulate standards for public and private providers and insurance companies and define the community-based service system. The state role in mental health financing focuses on mental health services through appropriations to state mental health agencies and other related agencies. The block grant system of federal fund allocation has further broadened the states' power by increasing their control over federal spending.

With today's fiscal belt-tightening, states cannot rely on increased revenues and must learn to make the most efficient use of existing dollars. States are challenged to create a funding mix for mental health and supportive services and to develop cost-effective strategies for program implementation.

106

This chapter describes the role of state, local, and private funding of mental health services and examines strategies to make the most efficient use of those resources at the state and local levels. These strategies include managing mental health care, shifting resources from hospital to community services, mandating mental health insurance, establishing insurance risk pools, issuing bonds, revising surplus hospital property, and encouraging mental health centers to diversify into for-profit businesses.

State, Local, and Private Funding Sources

Individuals with serious mental illness require a number of services and supports. Some are essential to help them live productive lives in the community; others are necessary in emergencies; still others enhance the quality of their lives. Funding for these services comes from a variety of sources. Federal financial support for those with serious mental illness was described in Chapter Five. Following are descriptions of state, local, and private sources of funding.

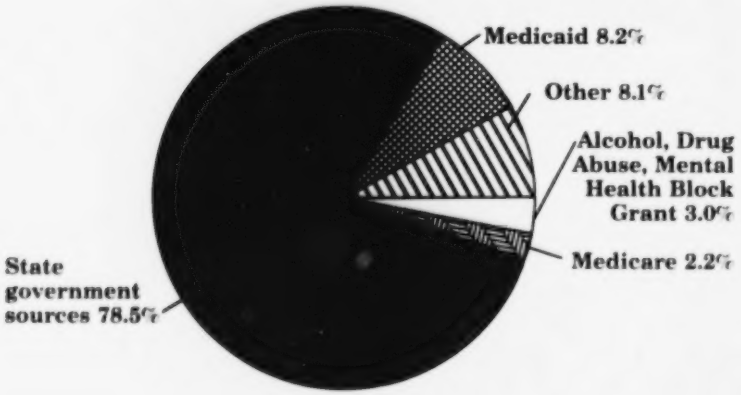
State Governments

In 1985, states supplied over 78 percent of the funds to support state mental health agencies.[1] The remainder was provided by federal sources, including block grants, Medicare, and Medicaid. (See Figure 6-1.) The state appropriates funds to its state mental health agency, which distributes the money to the state mental hospitals and to local agencies, which deliver services to the community. These agencies may be public and private providers contracted by the state to provide specific services. States further influence mental health financing by passing laws that regulate standards for public and private providers and third-party insurers.

Nationwide, state mental health agencies directly controlled and administered more than $8.3 billion dollars for mental health services in FY 1985.[2] As a percentage of total state revenues, funding for mental health services averaged 1.92 percent, with a high of 3.42 percent in New York to a low of 0.38 percent in Alaska.[3] The per capita expenditure varied dramatically, from a high of $90.12 in New York to a low of $10.51 in Iowa, as shown in Figure 6-2. Iowa's per capita spending is misleading, however, because it is the only state that funds most mental health services through county taxes.

Figure 6-1.

State-Controlled Revenues for the Mentally Ill
Where the Money Comes From



Source: *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 34 (September/October 1987): 3-6.

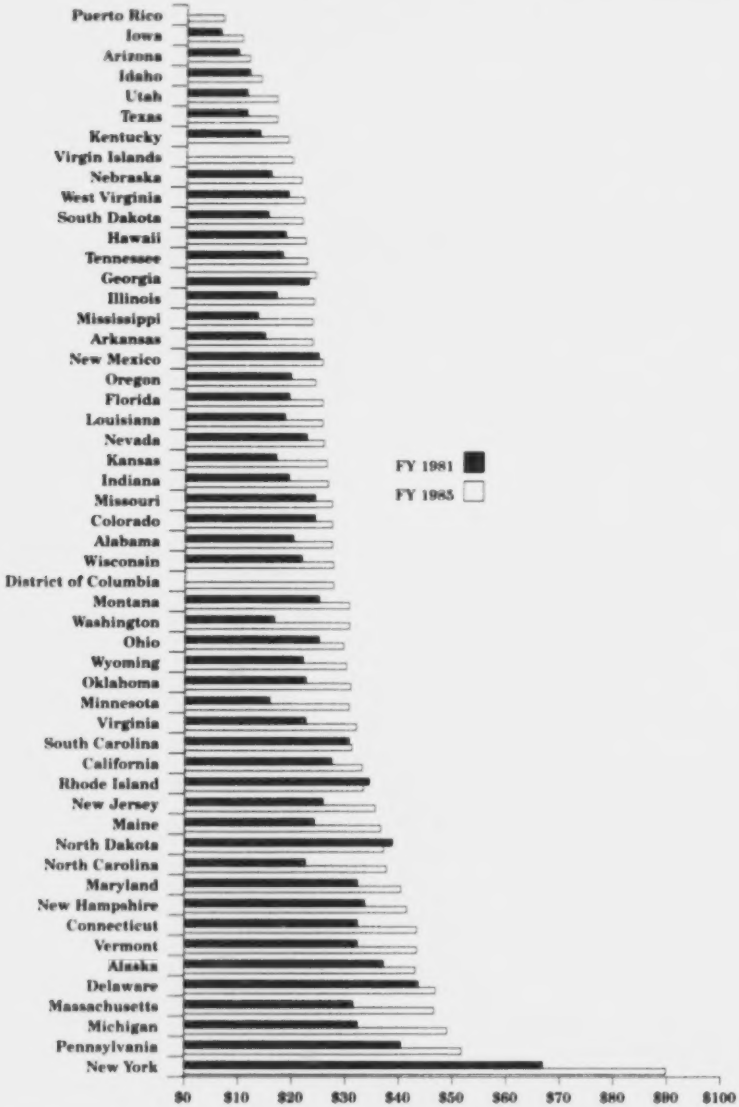
Local Governments

Local government participation in mental health financing can be divided into five different models, depending on how services are organized in each state:[4]

(1) The counties share funding responsibility for mental health services with the state, which provides the services directly or through private contractual agreements.
(2) The counties share with the state in funding mental health services, which are provided by the counties or by local mental health boards.
(3) Mental health services are funded completely by the state, which provides mental health services directly or through private contractual agreements.
(4) County and state governments provide mental health services primarily through public contractual arrangements and share in the funding of local mental health services.
(5) The state and county governments jointly provide mental health services, and counties share in funding local mental health services.

Figure 6-2.

Per Capita Expenditures by State Mental Health Agencies for Mental Health Services: United States, FY 1981 & FY 1985



Source: *Mental Health, United States, 1987*, National Institute of Mental Health.

Approximately 25 states use matching formulas to distribute mental health funds to counties. Matching funds act as an incentive for local governments to raise local dollars and to participate in planning a cost-effective system of mental health services.[5] Local matches for specific purposes can also encourage or discourage use of services. For example, states can require a county match for state hospital care, but no match for local outpatient services. Often, local funding is directed at services that receive little state and federal funding, such as prevention and early intervention services, youth outreach, and public education.[6]

Some states are giving local government more control over financing. For example, Wisconsin allocates money to the counties, which are responsible for reimbursing all aspects of mental health care, including buying back bed days from the state hospital. Ohio passed legislation in 1988 that merges clinical, legal, and funding authority at the local level. As more states turn over financial control to the local authorities, local power will increase.

While local mental health boards or governmental units participate in mental health financing through administrative control over funding, direct delivery or contracting of services, and the establishment of priorities, the actual dollar contribution is small. Of the $11.1 billion spent by all levels of government to care for those with serious mental illness in 1983, only 2.7 percent was provided by local government.[7] (See Figure 6-3.) Clearly, if local units of government expect to improve the current system of delivering services to persons with serious mental illness, they will have to contribute more local dollars for that purpose.

Private Foundations

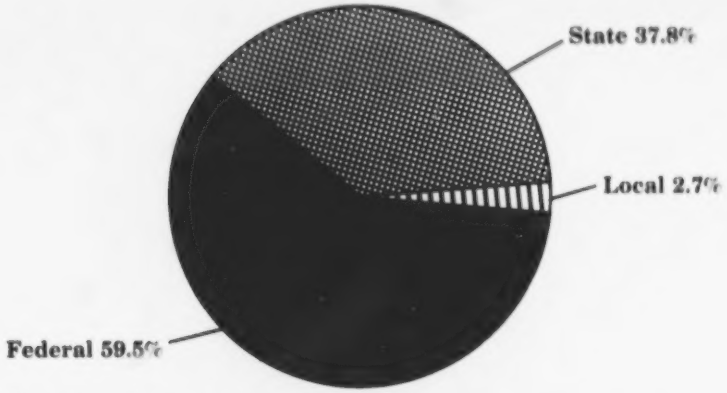
The United States is the only country that has private grantmaking foundations contributing money to the public good. Some 23,000 foundations with over $50 billion in resources provide $4 billion in grants each year, of which $700 million goes to health-related projects.[8]

Foundations have been influential in mental health policy by strategically targeting programs and issues not generally supported by government, including innovations in mental health service delivery and the education of mental health professionals.

The Robert Wood Johnson Foundation, with the U.S. Department of Housing and Urban Development (HUD), has provided more than $100 million in grants, loans and rent subsidies to nine of the nation's largest cities. The funds are being used to develop a continuum of housing, mental health, rehabilitation, and social services for people with serious mental illness. (Details of these programs are discussed in Chapter 3 and Chapter 6).

Figure 6-3.

Estimated Expenditures for the Chronically Mentally Ill



Total expenditures = $11.1 billion.

Federal category includes expenditures for the following programs: Medicare, Medicaid, SSI, SSDI, block grants, Title XX, and housing.

State category includes Medicaid and direct allocations.

Source: Barbara Dickey and Howard H. Goldman, "Public Health Care for the Chronically Mentally Ill," *Administration in Mental Health* 14, no. 2 (Winter 1986): 63.

Some foundations have targeted local mental health programs. The Hunt Alternatives Fund supports programs in Colorado and Texas, and the McKnight Foundation focuses on Minnesota. Other foundations offering grants to benefit those with serious mental illness include the Catherine T. and John D. MacArthur Foundation, the Ittleson Foundation, the Van Ameringen Foundation, and the Pew Memorial Trust.[9] Although private foundation spending is dwarfed by federal and state mental health outlays, it represents a source of potential funds to support special projects.

Insurance Companies

Most private insurance plans cover inpatient psychiatric care for 90 days and offer limited payment for some of the services provided by community mental health centers and other public programs. Insurance policies tend to discourage the use of hospital alternatives because of caps on outpatient care through limitations on office visits or amounts paid per visit. In most plans, the

patient must pay for half of the outpatient costs, compared to 20 percent for other illnesses.[10] Plans with fewer employees generally have more restrictive coverage for mental health.

Faced with rising health care costs for their employees, business and industry are uniting to find ways to keep their employee insurance costs down, thereby making their products more competitive. At present, health care and other benefits represent 38 percent of labor costs.[11] Mental health services typically account for 20 to 25 percent of health care claims, a 15 percent rise in the past two years.[12] Many employers consider dental care and mental health services to be obvious places to economize. In the future, third-party payors, responding to business demands for cost-cutting measures, will probably increase efforts to shift more costs of mental health coverage to consumers.

Insurance reimbursement for mental health services generally affects children under 18 who are still covered under the family's policy. However, adults with serious mental disabilities are usually left to be cared for by the public system because they do not hold down jobs long enough to obtain private insurance coverage, or they have illnesses so serious that they quickly exhaust their benefit limits. In addition, people with serious mental illness require expensive support services that are not covered by insurance, such as vocational rehabilitation, housing, and social rehabilitation. In the future, it is unlikely that private insurance will be a significant source of funding for those with serious mental illness. However, the Arkansas Court of Appeals found in the 1987 case, Arkansas Blue Cross and Blue Shield Incorporated vs. John Doe, that manic depression is a biological and physical illness which entitled the plaintiff to the same medical benefits as other biological illnesses. This decision may impact mental health coverage in the future.[13]

Strategies to Finance Mental Health at the State and Local Levels

Faced with increasing demand and decreasing funds for mental health services, states are looking for creative ways to stretch their dollars and use funds more efficiently. Following are some innovative state funding strategies.

Strategy: Managed Care for Seriously Mentally Ill Persons

Managed care refers to a host of health care delivery models that attempt to keep costs down by "managing" the care to eliminate unnecessary treatment and reduce expensive hospital care. This is accomplished through measures such as capitated payments (paying a fixed amount per patient, regardless of the services used), continued stay review (periodic checks to verify that the patient needs to be in the hospital), or financial incentives to use certain providers. The most familiar models of managed care are the health maintenance organization (HMO) and the preferred provider organization (PPO).

For the provider, the advantage of managed care is a guaranteed population of patients. The buyers, both businesses and states, benefit by having fixed costs and eliminating the uncertainties about resources required to serve the patients.

Most people with serious mental illness are effectively excluded from private insurance managed care plans because of the limitations on service or high copayments. Any kind of managed care for this population will probably have to be funded by public resources. Two major models that states could use are:

- *Health Maintenance Organizations.* The state pays a selected HMO a capitated rate to provide a specific range of services to those with serious mental illness. The HMO assumes the risk of as well as the responsibility for providing a range of services for the capitated population—absorbing the loss if the funds are not sufficient to cover the services offered in the specified timetable.
- *Preferred Provider Organizations.* The state selects a limited number of providers in a geographic area who agree to provide a range of services to people with serious mental illness. The providers offer discounts to the state in exchange for the volume of referred clients and rapid payment. The clients can choose among the participating providers, unlike HMOs, where the client must go to the HMO provider. The state determines client eligibility, and the providers have a limited ability to reject referrals.[11]

In organizing a capitated payment managed care plan for persons with serious mental illness, it is difficult to adjust capitation rates based on a patient's health status. Capitated health plans for the general population have remained financially sound because

members are charged a single capitated rate based on actuarial estimates of risk. In this way, the healthy patients subsidize the sick ones. But if all the people covered by the plan are at risk, the providers must protect themselves and guarantee adequate resources to meet the patients' needs.

One scenario involves assigning patients to risk groups with set rates, based on time that the subscriber has spent in mental hospitals, past use of services, or risk determination. This approach has been used in Rochester, New York. However, the pitfalls of capitated plans for the public sector are significant, and states will be looking carefully at the demonstration projects in Philadelphia, Pennsylvania; Rochester, New York; and Hennepin County, Minnesota; to learn from their experiences.

New York. The New York Legislature authorized a demonstration project in 1978 to test new methods in organizing, financing, and delivering mental health services. The Monroe-Livingston County Project in Greater Rochester created a capitated payment system for those with serious mental illness. A private, not-for-profit corporation, Integrated Mental Health, Inc. (IMH), was established to provide community-wide planning, coordination, and financial management for mental health services.

IMH serves as a funding pool, collecting funds from the state, the counties, United Way, and private grants. Capitated payments are distributed on a monthly basis to five community mental health centers, called lead agencies, which agree to provide or purchase a package of mental health services, including inpatient care. Ten percent of the initial payment is deducted and placed in an insurance fund protecting the lead agencies and the capitation payment system program. Because the lead agencies must pay for inpatient care out of their capitated payments, they have a powerful incentive to expand outpatient and residential services to keep clients out of expensive inpatient programs.

The lead agencies are paid according to different capitation rates for three risk groups: $44,000 for continuous treatment patients who have spent 270 days or more in the state hospital during the past three years; $18,000 for intermittent patients who have spent 45 to 269 inpatient days; and $4,000 for outpatients who are currently enrolled in a state hospital's outpatient program. The rates are based on a percentage of current per diem inpatient state hospital costs. Enrollees are currently chosen from among state mental hospital patients. During the first year, which began in late 1987, IMH expects to enroll 100 continuous patients, 200 intermittent patients, and 200 outpatients.[15]

The project has encountered a number of problems in the developmental stages. State and local government, as well as provider agencies, initially resisted the idea of a local mental health authority that forced each group to give up some control in exchange

for service integration. The criteria and capitation rates for the three risk groups were the source of extensive debate. The state hospital employees' unions agreed to the plan only after assurances that employees would be transferred to jobs in newly developed services as the hospital scaled down.[16] Despite the developmental problems, the project should provide invaluable information to other states.

Minnesota. Beginning in 1986, Hennepin County, the urban county where Minneapolis is located, contracted with six private, prepaid health care providers and one county center to provide capitated health care services, including mental health, to 35 percent of its Medicaid-eligible population. Four providers contracted to care for people with mental illness, and the other three contracted to care for the aged and Aid to Families with Dependent Children (AFDC) populations.

Problems have plagued the project. The largest participating provider, Blue Cross/Blue Shield's (BC/BS) HMO, contracted to serve the population with serious mental illness. BC/BS was unfamiliar with patients suffering from serious mental illness and experienced problems with the capitated care program in general. After losing money, BC/BS decided to pull out. The patients who were served under this plan will revert to a fee-for-service reimbursement plan. The project will continue for clients served by other providers. It remains to be seen if the other providers will run into similar problems.[17]

Pennsylvania. With help from the Robert Wood Johnson Foundation, Philadelphia is establishing a public mental health authority that will determine capitation rates for Medicaid-eligible clients, reimburse community mental health centers on a capitated basis, and perform utilization review, including preauthorization for inpatient admissions and subsequent review of patient stays. The authority will pool funds from the state, the Philadelphia Office of Mental Health/Mental Retardation, and Medicaid, which has agreed to turn over 95 percent of its previous year's expenditures to the authority in exchange for guaranteed care of all Medicaid-eligible clients.

Starting in 1988, the program will serve approximately 100,000 Medicaid-eligible clients with serious mental illness in South and West Philadelphia. The plan will then expand to cover all of Philadelphia's 350,000 mentally ill, Medicaid-eligible clients. The community mental health centers will offer a full range of services to this population. Vocational and residential services are provided, but are not included in the capitation rate. These services will be paid for by city funds, RWJ funds, HUD's Section 8 certificates, and existing residential resources.

The plan calls for clients to be cared for by program support teams consisting of a psychiatrist and a case manager. The psychi-

atrist will be employed half-time and paid a capitated rate to take on public patients. Patients may be admitted to private hospitals where these physicians have admitting privileges. However, since the physicians must pay for inpatient care out of their capitated fee, the incentive will be to keep patients out of the hospital. Case managers will coordinate all aspects of the clients' care.[18]

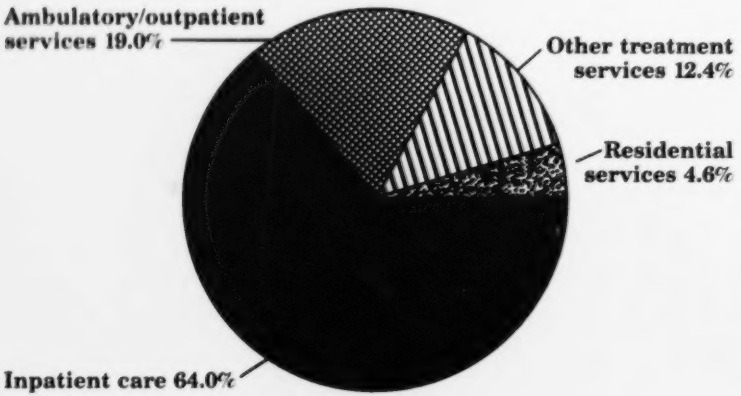
Strategy: Shift Funds from Hospital to Community Services

Studies have shown that offering comprehensive care for individuals with serious mental illness in the community results in reduced hospital admissions. However, most states do not have the necessary funds to build up community services because inpatient care consumes such a large portion of the budget. In 1985, states spent an average of 64 percent of their mental health budget on inpatient care.[19] (See Figure 6-4.) States are looking for ways to limit the use of inpatient care and shift resources to community services.

As discussed in Chapter Three, structural changes that combine the funding and program responsibility at the local level can help redirect funds from the hospital to the community. However, states that are not ready to make a major structural overhaul are

Figure 6-4.

State-Controlled Revenues for the Mentally Ill
Where the Money Goes



Source: *State Health Reports: Mental Health, Alcoholism and Drug Abuse,* no. 34 (September/October 1987): 3-6.

looking into other ways to shift funds. Vermont's efforts to develop the community services needed by discharged hospital patients has been so successful that the state is considering closing the hospital for all but forensic patients. Another strategy involves identifying hospital patients who can be discharged from the hospital, developing community service alternatives for these clients, and then eliminating beds and reducing hospital positions or shifting hospital staff to new community jobs. Louisiana has successfully employed this strategy. Other states, including Rhode Island and Texas, offer cash incentives to transfer patients from the hospital and care for them in the community.

Vermont. Vermont is a long-time leader in shifting patients from the hospital to the community. The state has organized its community centers specifically to respond to the needs of patients released from the state hospital to prevent rehospitalization. Between 1981 and 1983, half of the state hospital's 300 clients were transferred from the state hospital to the community.[20] This effort has been so successful, and the recidivism rate of these clients so low, that a legislative joint committee recently recommended phasing out the hospital for all but the forensic patients and the patients who are the most difficult to manage. Money saved from closing the hospital wards and renting the hospital for state office space will be used for additional community services. Medicaid will provide additional funding, since 55 percent of state hospital patients would become eligible upon discharge, as compared with 11 percent of inpatients who are currently eligible.[21]

Louisiana. The East Louisiana State Hospital selected 96 patients from six wards who were capable of living in the community and transferred them to an inpatient unit with a structured transition program. Participants learned to take care of themselves, take their own medicine, and get along with people. Some job training was offered as well. A $271 one-time salary bonus attracted staff to the program. As patients were discharged from the hospital, wards closed and staff members transferred to vacancies in other programs. To support the clients in the community, the hospital earmarked slightly more than one million dollars in hospital resources, or 64 percent of the total costs of institutional care for this group. Funds were accrued by eliminating 80 hospital personnel positions through attrition. After one year of community placement, only 14 percent of the participants have returned to the hospital, compared to a 50 percent recidivism rate for other East Louisiana State Hospital discharges.[22]

Texas. In response to a court order, the Texas Department of Mental Health and Mental Retardation developed a plan to reduce utilization of the eight state hospitals. Community centers and

community programs of the state hospital are paid $35.50 per day for each patient day they eliminate from the state hospital census. From 1985 to 1987, these community centers and programs received $38.5 million and reduced state hospital patient days by one million dollars.[23]

Rhode Island. The Transfer I program offers community mental health centers $5,000 to transfer a patient who has been in the hospital for 120 days or less to community programs. Transfer II offers community centers $20,000 to transfer patients who have been hospitalized for 365 days or more. At present, approximately 600 patients have been successfully relocated to the community under the Transfer I program, and 96 patients have been transferred under the Transfer II program.[24]

Strategy: Mandated Health Insurance Coverage

Mental health advocates have lobbied legislators to secure mandated benefits for private mental health insurance coverage. At present, about 27 states regulate mental health benefits. Advocates claim that mandates are necessary because the stigma attached to mental illness prevents consumers from demanding much-needed coverage. Many legislators feel that adequate mental health coverage would relieve some of the demand for public services. Most agree that the increased mental health coverage in private insurance policies over the past 10 years can be attributed largely to state mandates.

The insurance industry has been the major opponent to mandated coverage. It argues that mandated benefits stifle competition and discourage cost-containment efforts that would ultimately benefit consumers. The opposition from business and industry focuses on concerns of increased costs. Some policymakers fear that mandates may raise the cost of doing business and put their states at a competitive disadvantage in attracting new businesses.

States debating whether or not to mandate private insurance benefits for mental health may want to consider several factors: "a definition of the term 'mental illness and nervous disorders'; type and extent of treatments to be covered; treatment settings and standards to be met by provider agencies; quality assurance procedures; identification of professional providers who will offer treatment; and the types of policies and third-party payors that are included or excluded from the mandate."[25]

Advocates who favor mandates make the following recommendations for benefits to be included in legislation: treatment coverage of inpatient care for at least 45 to 60 days with no distinction between general and psychiatric hospitals; outpatient care at a

minimum of 20 to 30 visits per year; and between 45 and 90 days per year as a minimum for partial hospitalization.[26]

State activity on mandates affects children with serious mental illness who are covered under the family's policy. However, the number of adults suffering from serious mental illness who are covered under private insurance is so small that states should not view mandated mental health benefits as an effective way to finance services for this population.

Of the states regulating mental health benefits in private health insurance policies, 14 have mandatory coverage statutes that require insurers to pay for mental health care in certain types of insurance policies. (See Figure 6-5.) These states include Arkansas, Colorado, Connecticut, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia, and Wisconsin. Of these states, Arkansas, Connecticut, Maryland, Mississippi, and Virginia make the mandatory coverage applicable to individual as well as group contracts.

Thirteen states require that insurance policies offer mental health coverage at the policyholder's option. These states include California, Florida, Georgia, Illinois, Kansas, Kentucky, Louisiana, Missouri, New York, Tennessee, Vermont, Washington, and West Virginia. Three states—Connecticut, Maryland and Virginia—have both mandatory and optional provisions.[27]

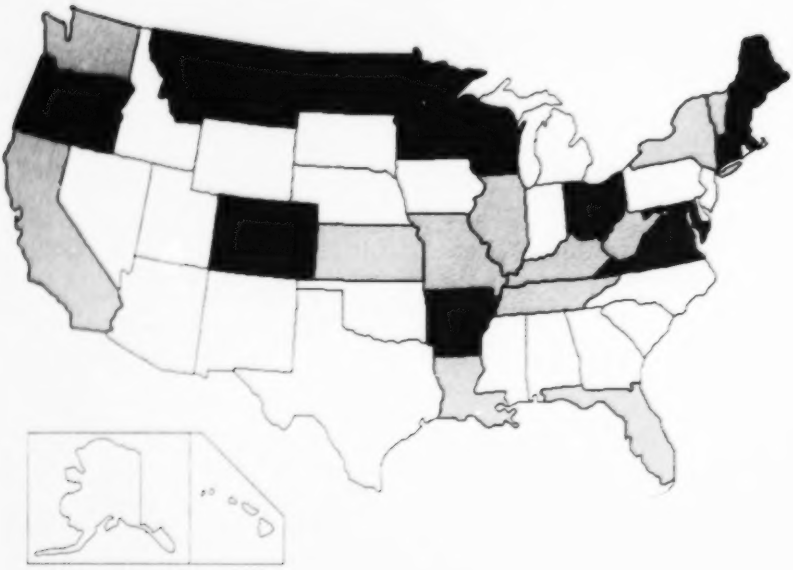
Strategy: Risk Pool Coverage of Mental Health Services

Because many high-risk patients, such as individuals with serious mental illness, have trouble obtaining private insurance, some states have enacted laws to create comprehensive health insurance associations, known informally as risk pools. These associations offer health insurance coverage to people who have been rejected by insurance companies and people who are not eligible for Medicaid, but who might exhaust their savings and become medically indigent as a result of an extended illness. Under the laws, all insurers doing business in the state are required to join the association and offer individual, comprehensive health insurance to people who are considered uninsurable.

At present, 15 states have created risk pools: Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oregon, Tennessee, Washington, and Wisconsin. Maine's risk pool is a demonstration project that will be subsidized through an assessment on hospital revenues. Coverage for mental health benefits varies significantly under these statutes. Most of the risk pools have placed limitations on outpatient mental health. Some have limited inpatient

Figure 6-5.

States with Mandated Private Mental Health Insurance Benefits



■ **States that mandate mental health insurance**

■ **States that require insurance policies to offer mental health coverage at the policyholder's option**

■ **States with mandatory and optional provisions**

Source: *State Health Reports: Mental Health, Alcoholism and Substance Abuse*, no. 20 (January 1986): 7-9.

services, and others have specifically excluded mental health coverage.[28] Because risk pools are relatively new, their application to individuals with mental illness remains unclear.

Strategy: Bonds to Finance Capital Improvements

The trend toward decreasing the number of beds at state mental hospitals has not eliminated the need for capital improvements. In many states, hospital buildings are in disrepair, safety

hazards prevent accreditation, and enormous campuses stand largely empty, while interconnected heating systems waste energy. Financing is needed for renovation, conversion of empty space to alternate uses, and construction of housing units or community centers for those with mental illness. In selecting financing options for capital improvements, state legislators need to review traditional as well as new approaches to capital financing, taking into account their own state's needs and the new tax environment.

For capital projects, states have three choices: pay now, lease, or borrow. Paying for it now involves a lump sum or annual appropriation, which is often difficult with tight budgets and political uncertainties. Leasing requires states to pay a third party for the use of equipment or facilities. Debt financing involves the use of bonds, in which the money to pay for a project is borrowed through the sale of bonds and paid back over time.

Federal tax reforms enacted between 1981 and 1986 have changed the capital finance environment, making taxable municipal bonds possibly more attractive. The reforms have also increased the cost of issuing bonds by placing volume caps on certain types of municipal bonds.[9]

Colorado. The state Division of Mental Health worked with a local investment firm, the Colorado Health Care Financing Authority, and a bond insurance firm in New York to set up a pooled bond fund. The money was used to build new residential and treatment facilities, purchase vans and other equipment, and refinance existing debt for private nonprofit providers of services to persons with serious mental illness or developmental disabilities. In a creative mechanism used for the first time by Colorado, contracts with providers specify that the Division of Mental Health will take the first part of their earnings to send to a trustee as payment on the debt. The state is not obligated in any way. However, giving the Division of Mental Health the responsibility for making the payment gave the bond insurer the confidence necessary to issue insurance. The added security of insurance allowed the bonds to receive a triple-A, double tax-exempt rating at an effective rate of 7.5 percent, which includes administrative costs. A total of $15 million in bonds was issued in 1987 and another $10 million in bonds will be issued in the summer of 1988.[10]

Massachusetts. As part of a five-year plan to improve services for those with serious mental illness, Massachusetts passed a capital outlay bill that will provide a general obligation bond issue of $340 million to improve the state's mental hospitals and community mental health centers and provide housing for people with serious mental illness. The bond issue will give the state the resources to achieve a balanced system of care that includes first-

rate hospitals and comprehensive community services and housing. A total of $207 million is reserved for renovating mental hospitals. Housing will account for $83 million, including 2,500 additional housing units, some financed through capital, and others developed through rent subsidies of existing buildings. Another $49.9 million will provide for renovation and construction of acute inpatient facilities in community mental health centers, with a small amount set aside to correct safety and deferred maintenance problems at the centers. The legislature will add $110 million to the state mental health agency appropriations over the next five years to cover operating expenses.[31]

Strategy: Reuse of Surplus Hospital Property

Although the number of public mental hospital patients has declined by almost 80 percent in the last 25 years, only 16 of the 274 state psychiatric hospitals have closed. Consequently, many state psychiatric hospitals are in the position of having empty buildings and surplus land that could be a source of funds or benefits for those with serious mental illness. Potential exists to rent or lease empty buildings to new users or to lease land to private residential developers in exchange for a specified number of housing units to be set aside for mentally disabled clients.

A recent survey of 258 state mental hospitals revealed that more than 370 buildings and 20,000 acres of land were transferred to new owners between 1970 and 1985. This property constituted 11 percent of the land in use at state hospitals in 1985. Another 450 hospital buildings were vacant in 1985.

As shown in Table 6-1, state governments were the most frequent users of surplus hospital property, sponsoring 43 percent of the reuse activity. Nonprofit organizations accounted for 17 percent of the transfers while county government, local government, and private organizations each sponsored slightly more than 10 percent of the reuse projects. Reuse activities reported in the survey included conversion of property into alcohol and drug treatment units; facilities for the mentally retarded; prisons and juvenile detention programs; state offices; recreation, agricultural and housing programs; sheltered workshops; and education, transportation, and manufacturing facilities.[32]

Massachusetts. The state's five-year plan to improve services for individuals with serious mental illness calls for creative approaches to establish community-based beds. The Department of Mental Health has identified a large number of buildings and parcels of land on state hospital grounds that are no longer needed. Some of the land, which was outside the city limits when the hospitals were built, is now prime real estate within the city.

Table 6-1.
Types and Sponsors of Reuse of State Hospital Property, 1970-1985

Type of Reuse	Sponsors							Total	
	Federal	State	County	City	Nonprofit	Private	Other	No.	%
Mental health									
Alcohol and drug treatment		8	2		5	2		17	7
Mental retardation		9	1		4			14	6
Sheltered workshop		1	1		4			6	2
New mental hospitals		3						3	1
Other		8	3		10	3		24	10
Corrections									
Adult prison		14	1					15	6
Juvenile detention		4	4		2			10	4
Other		1			1			2	1
Other									
Education	1	7	6	4	6		2	26	10
Office space		21	2	1				24	10
Recreation		4	6	9	2		1	22	9
Agriculture		7	1	1	1	6		16	6
Housing		4		2	3	7		16	6
Transportation		3		3			1	7	3
Manufacturing		1		2		1		4	2
Miscellaneous	3	6	3	2	2	1		17	7
Vacant after transfer		6	1	3	2	4		16	6
No use identified		1	1	1		7		10	4
Total cases of reuse									
No.	4	108	32	28	42	31	4	249	
Percent	2	43	13	11	17	12	2		100

Source: Lawrence W. Dolan, "Reuse of State Hospital Property, 1970-1985," *Hospital and Community Psychiatry* 35, no. 4 (April 1987): 409.

Under one plan, the state would sell land for residential development to private developers at reduced prices. In exchange, the developers would permanently set aside 10 percent of the units—approximately 470—to be used by Department of Mental Health clients.[33]

Strategy: Encourage Entrepreneurship for Community Mental Health Centers

Because federal, state, and local support is not keeping pace with community demand, some mental health centers are experimenting with providing some services at a profit to subsidize other programs. If successful, these entrepreneurial efforts can benefit both the state and the mental health center by making money available for capital improvements, new programs, and staff salary raises. There may be spillover benefits when resources, skills, motivation, and knowledge gained through entrepreneurial efforts are applied to public programs. The state can also gain political credibility and become recognized for its innovation and leadership in creating a partnership with the private sector.

However, there are risks involved as well. The state will have to sacrifice control over the money-making ventures, while still remaining vulnerable to bad publicity if the entrepreneurial efforts fail. Advocates for those with mental illness may perceive the money-making ventures as a sign that the mental health center is abandoning its core mission, with potential political fallout for the state. To avoid this, state mental health agencies must stipulate that entrepreneurial activities must subsidize the cost of care for individuals with serious mental illness or benefit those who use public services.

Legislators and state mental health agencies can take steps to help create an environment for entrepreneurial activities to succeed:[34]

- Set clear guidelines on how profits are to be used. The state needs to make sure that the profits will be reinvested in services not otherwise reimbursed, and the mental health center needs assurance that the state will not deduct all of the profits from the following year's funding.
- Establish performance indicators to make sure that those most in need continue to be served by programs.
- Provide separate funding to seed ventures. States may want to establish a state revolving fund for working capital, obtain private capital funds to underwrite ventures, require centers with successful entrepreneurial

programs to contribute to a common pool, or underwrite borrowing to provide working capital.

- Provide technical assistance. Since most mental health administrators and managers are not experienced in entrepreneurial activities, technical assistance can help centers develop business and marketing plans. The state mental health agency should also be prepared to monitor these activities to maintain state priorities.
- Pass legislation to make restructuring easier. Community centers can prevent the combining of public and private money by restructuring to establish separate entities for the profit-making ventures. State legislative action can make restructuring easier.

For these steps to work, state authorities must be willing to give up some financial and programmatic control so the centers can successfully compete in the marketplace. Successful entrepreneurial activities include programs in Colorado Springs, Colorado; and Derry, New Hampshire.

Colorado. Pikes Peak Mental Health Center, in Colorado Springs, Colorado, has established a nonprofit organization system with five separate corporate entities. A separate but interlocking governance system provides coordinated direction. The nonprofit body allows flexibility to structure services to meet community needs more effectively while avoiding the excessive bureaucratic control and expense that often accompany government funding. The center has obtained revenues from a variety of unrelated businesses. The center owns and leases land to a fast-food restaurant, using the profits to support mental health services. The center also owns and leases 36,000 square feet in a shopping mall.[55]

New Hampshire. The Center for Life Management in Derry, New Hampshire, chose to aggressively market their services to increase their market share and supplement the shrinking state and federal revenues. The organization is divided into several separate departments that provide marketable services as well as mandated state services.

Three of the center's departments operate on a private, for-profit basis: a private association of professionals offering consulting services in strategic planning, training, and human resources management; a clinic for behavioral and eating disorders; and therapists who provide traditional fee-for-service short-term treatment.

One of the three departments is devoted to treating clients with serious mental illness and is supported by state funds. It offers day treatment, partial hospitalization, residential and voca-

tional rehabilitation, and case management services. Another state-supported department provides 24-hour emergency psychiatric care and determines the most appropriate placement for the client in one of the organization's programs or at a contracting inpatient care facility.

The center is able to furnish services to the 25 percent of its nonpaying clients, because 75 percent of the clients pay for services. The program currently receives 62 percent of its financial resources from nongovernmental sources. Of this amount, 49 percent of the facility's revenues is provided by third-party insurance reimbursements, and the remaining 13 percent is obtained from out-of-pocket fees, contract arrangements, and training.[36]

Conclusion

With the increasing scarcity of resources to fund programs for those with serious mental illness, states are turning to innovative financing strategies. Capitated managed care programs for individuals with serious mental illness offer one of the most promising ways for states to make the most efficient use of existing funds by controlling excessive inpatient care. Shifting funds from hospital to community services is a clinically sound and fiscally feasible strategy for states to adopt. Bonds offer states a way to finance capital improvements without increasing appropriations. Conversion of state hospital buildings and property offers another potential source of funds. Finally, states can encourage community mental health centers to diversify into for-profit businesses to subsidize public programs. Whatever approaches states take to fund mental health programs, the climate of fiscal austerity will demand creativity and vision on the part of legislators.

Notes

1. Theodore C. Lutterman et al., "Trends in Revenues and Expenditures of State Mental Health Agencies, Fiscal Years 1981, 1983 and 1985," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 34 (September/October 1987): 5.
2. Ibid., p. 3.
3. Ibid., p. 5.
4. Margaret M. Hastings, *Financing Mental Health Services: Perspectives for the 1980s* (Rockville, Md.: National Institute of Mental Health, 1986), p. D-3.
5. Ibid., p. 1-34.
6. Ibid., p. 1-32.

7. Barbara Dickey and Howard H. Goldman, "Public Health Care for the Chronically Mentally Ill: Financing Operating Costs, Issues and Options for Local Leadership," *Administration in Mental Health* 14, no. 2 (Winter 1986): 64.

8. Linda Aiken et al., "Private Foundations in Health Affairs: A Case Study of the Development of a National Initiative for the Chronically Mentally Ill," *American Psychologist* 41, no. 11 (November 1986): 1290.

9. E. Fuller Torrey and Sidney M. Wolfe, *Care of the Seriously Mentally Ill: A Rating of State Programs* (Washington, D.C.: Public Citizen Health Research Group, 1986), p. 92.

10. Adrienne Lang, "State Laws Mandating Private Health Insurance Benefits for Mental Health, Alcoholism and Drug Abuse," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 20 (January 1986): 4.

11. Hastings, *Financing Mental Health Services: Perspectives for the 1980s*, pp. 2-22.

12. Cynthia Wallace, "Employers Turning to Managed Care to Control Their Psychiatric Costs," *Modern Healthcare* 17 (July 13, 1987): 82.

13. Phil James, Legislative Assistant, National Alliance for the Mentally Ill, May 1988: personal communication.

14. "Toward a Model Plan for a Comprehensive, Community-Based Mental Health System" (Rockville, Md.: National Institute of Mental Health, October 1987), p. 53.

15. Barbara Dickey, Assistant Professor, Harvard Medical School, December 1987: personal communication.

16. Anthony F. Lehman, "Capitation Payment and Mental Health Care: A Review of the Opportunities and Risks," *Hospital and Community Psychiatry* 38, no. 1 (January 1987): 36.

17. Barbara Dickey, December 1987: personal communication.

18. Ibid.

19. Theodore C. Lutterman et al., "Trends in Revenues and Expenditures of State Mental Health Agencies, Fiscal Years 1981, 1983 and 1985," p. 3.

20. La Vonne Daniels, "Retooling in the 80s—Transferring Dollars from Hospital to Community Programs," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 30 (March 1987): 4.

21. Paul J. Carling et al., "A State Mental Health System with No State Hospital: The Vermont Feasibility Study," *Hospital and Community Psychiatry* 38, no. 6 (June 1987): 620.

22. La Vonne Daniels, "Retooling in the 80s—Transferring Dollars from Hospital to Community Programs," p. 4.

23. Norene Hughes, Assistant Deputy Commissioner for Mental Health, February 1988: telephone interview.

24. Barbara Dickey, December 1987: personal communication.

25. Hastings, *Financing Mental Health Services: Perspectives for the 1980s*, pp. 1-38.

26. Ibid., pp. 1-39.

27. Adrienne Lang, "State Laws Mandating Private Health Insurance Benefits for Mental Health, Alcoholism and Drug Abuse," p. 7.

28. "Risk Pool's Coverage of Mental Health Services," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 23 (May 1986): 1.

29. Barbara Yondorf and Barbara Puls, *Capital Budgeting and Finance: The Legislative Role* (Denver, Colo.: National Conference of State Legislatures, November 1987): 82.

30. Bruce Berger, Administrator of Management Services, Colorado Division of Mental Health, April 1, 1988: telephone interview.

31. Gail E. Toff, ed., "Massachusetts Governor Signs Capital Outlay Budget," *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 33 (July/August 1987): 6.

32. Lawrence W. Dolan, "Reuse of State Hospital Property, 1970-1985," *Hospital and Community Psychiatry* 38, no. 4 (April 1987): 408-410.

33. Patrick Locke, Budget Analyst, Massachusetts Budget Bureau, March 2, 1988: telephone interview.

34. Curtis P. McLaughlin and William N. Zelman, "Entrepreneurship and State/Mental Health Center Relationships," *Community Mental Health Journal* 23 (Spring 1987): 60-75.

35. "Mental Health Services Financing: Innovative Programs and Approaches" (Denver, Colo.: National Conference of State Legislatures, February 1985), p. 2.

36. Ibid., p. 3.

VII

Future Challenges

The purpose of the mental health system in the United States has undergone a fundamental shift in the past three decades —from long-term management in a custodial setting to active treatment in diverse settings. As understanding of the variety of mental illnesses and resulting disabilities has grown, the complexity of the service system has increased. The system became fragmented as it expanded to include state, federal, local, and private providers of mental health care.

As a result, mental health policy no longer revolves solely around the state mental hospital. It includes all three levels of government and the private sector. It involves not only mental health treatment, but a variety of supportive and rehabilitative services. It contemplates assistance in a brief crisis, periodically, or over a lifetime, depending on the individual patient's needs.

One constant element, however, is the central role of state legislatures. Choices made by state lawmakers will play a dominant part in defining and realizing the mental health service system of the future. A primary challenge facing legislators is the development of a mental health system that fits the new reality, with comprehensive mental health policies as a foundation.

129

Challenges for State Policymakers

In the decentralized, interactive system of the future, state legislators must understand how all the needs, services, and funding of a mental health system fit together. Legislators have a special role in developing coherent policies to create a coordinated system.

State legislators establish laws for the states as the leading providers of public mental health care. They pass laws regulating licensing and monitoring of organized mental health programs and individual professionals providing treatment. Legislators' decisions will determine the level of resources available for mental health care. For example, each state's Medicaid program includes or excludes key mental health services. Legislators can determine whether Medicaid is the most appropriate and cost-effective place to channel resources or whether individuals needing care or support will be the responsibility of the mental health, social service, welfare, or other program budgets.

Reaching a new consensus on the purpose, the responsibilities, and the scope of the mental health system will be an important challenge for each state in the future. Formidable areas for legislators to address include setting priorities, developing coordination and flexibility, and establishing accountability.

Priorities. In a decentralized system, with limited resources, priority-setting is critical. Scarce resources require identifying the problems and populations most in need, both within the mental health sector and in comparison with other important state concerns. Since many patients now spend most, if not all, of their time living outside mental health facilities, comprehensive mental health funding is needed to promote important programs in housing, general health care (e.g., Medicaid), income support, and many other policy areas.

The overwhelming needs of some of the patients who were deinstitutionalized after years in the hospital and those of young adults with a severe, disabling mental illness demand priority consideration in the public mental health system. The lack of adequate services has exposed other critical problems, such as suicide among young people, alcohol and drug abuse, mental illness among the growing number of homeless families, as well as Acquired Immune Deficiency Syndrome (AIDS) victims, individuals at risk, and their families. Given the high priority and high cost of services to those with severely disabling illnesses, resources can be allocated more cost-effectively to prevent or intervene earlier to forestall or ameliorate the severity of mental disorders.

Legislators are faced with the challenge of finding new resources to fund new programs, while maintaining the existing ones. In the foreseeable future, however, new funds will be scarce. If movement toward an improved mental health system is to occur, difficult alterations in resource allocation will be necessary to provide sufficient funding for supporting significant change. Some current and long-standing demands may have to remain unmet to develop the service system that will be needed in the future. Too little attention to future priorities sets up the system of the future to fail and squanders today's tax dollars on short-term solutions.

Flexibility and Coordination. When the mental health system focused on institutionalization for all patients, the common element in policy and resource decisions was the development and capacity of the state mental hospital. Today, that system involves a variety of publicly funded services and programs, as well as a variety of informal services provided at low cost by families or consumer self-help programs.

State legislators, who hold authority over the range of mental health services, have a unique responsibility to set policy directions that encourage the coordination that is vital in a decentralized system. Currently, each service system develops an entire structure of policies concerning eligibility, hours, costs, program, and goals. The client is expected to adapt to the system, if he wishes to obtain the service. This works reasonably well as long as clients learn to utilize each service system. But the mental health client today needs a variety of complex services. In order to respond effectively to future clients, the service and funding system must be able to adapt. The challenge for state policymakers will be to design policies that best utilize available resources to enhance the capacity of the system to respond to the changing client population, as well as to the fluctuating needs of individual clients.

Accountability. There is a growing demand for increased accountability within the mental health system—to consumers, to the community, to funding sources—emphasizing cost containment, quality of care, and service effectiveness. Expectations for the system are increasing, while resources are constrained.

Factors Shaping the Future of Mental Health Services

While it may be difficult to achieve consensus on predictions, some factors that will be instrumental in shaping the future are

fairly clear. These may be divided into several categories: evolution of the health care system, economic and social trends, knowledge, demographics, and new problems.

Evolution of the Health Care System. Most public and private mental health care in the United States already occurs in the general health care system, not in the specialty mental health care system, and the trend is likely to continue. The evolution of the health care system—service structures, financing, monitoring, resource allocation, privatization—will exercise a powerful influence on similar issues in mental health. Rising health care costs will be reflected in mental health programming and funding, and cost-containment objectives will be a major theme. Another trend is growing recognition of the integral relationship between health and mental health.

Economic and Social Trends. A host of general economic, social, and political factors will help determine reasonable funding for mental health services and the taxpayer's willingness to support these services. The future course of poverty and unemployment, housing shortages, and the federal budget deficit will exert heavy pressures on mental health services. Changes in the socioeconomic structure of our society will have an impact on the incidence of mental illness, the ability of families and communities to provide support, the availability of interested individuals trained to provide mental health services, and public acceptance of persons with mental health problems living in the community. For example, the policy of deinstitutionalization was initiated during a period of rising affluence, increased sensitivity to individual rights, and expanding federal programs to provide income, housing, rehabilitation, and health care for those in need. By the time the policy reached full implementation, many of these factors had changed, eroding the premises on which deinstitutionalization was based.

Knowledge. Our knowledge about the treatment and management of mental illness continues to grow rapidly. Breakthroughs can never be predicted accurately, but the level of anticipation among researchers in this field is cause for hope. The ability to benefit from the knowledge gained from research and from experience will depend on the distribution and application of that information.

Advocacy. Groups representing consumers and their families are growing more visible and assertive. While often disagreeing with each other, these new groups bring a very different dimension to the political and policy process. Their influence is a primary element in focusing attention on the needs and experience of individual clients rather than the needs of the service system. With increased political sophistication, these groups will demand accountability of state mental health systems and the officials who operate the systems.

Demographics. The aging of the United States population will give increased prominence to the need for mental health services for the elderly, an area that has received little attention in the past. The even faster-growing proportion of persons over 75 years of age, for whom the incidence of mental problems is high, will demand concerted attention. The relationship between the mental health care system and the long-term care system for the elderly will be a primary factor in defining the scope of mental health services. At the same time, the growing number of children in poverty and the changing proportions of various population groups will have important implications for the design of mental health services.

New and Emerging Problems. At any given time, new problems will emerge into the public policy consciousness and demand consideration and resources. Today, some of these problems are:

- Young adults with severe, disabling mental illness. The "new generation" of persons who have the types of illness that would once have led to long-term hospitalization has begun to attract the attention of service providers, communities, researchers, and policymakers. These individuals now spend virtually all their lives in the community. While many manage to live relatively satisfying and successful lives with the help of family, friends, and community-based treatment and support programs, a small but significant number have multiple problems involving mental disorders, substance abuse, and legal problems. This group may need the assistance of many programs in various systems. They may be the most difficult, costly, and numerous clients, absorbing a high proportion of the total resources of several programs.
- Mental illness and homelessness. Some people with serious mental illness are also homeless. These include deinstitutionalized patients, those receiving care in the community, and those never in active treatment. While complete statistics are not available, some recent local surveys estimate that persons with mental illness represent from 25 to 40 percent of today's homeless population.[1]
- Acquired Immune Deficiency Syndrome (AIDS). An example of an unpredictable problem is the AIDS epidemic. Although primarily a general public health concern, AIDS has significant mental health ramifications, ranging from dementia among victims to stress among victims and their families.

The Public Mental Health System in the Year 2010: A Scenario for the Future

Policy choices create results, and thinking about a scenario for policy options can serve to clarify priorities and policy outcomes. The answers to the following questions can suggest a picture of mental health services in the year 2010.

Who Will Be Served?

Demographic imperatives, resource constraints, and the demands of communities and constituencies are likely to ensure a continuing high priority for three population groups: the elderly (generally in nursing homes rather than mental health facilities, with increased emphasis on home care); those with long-term, serious mental illness who are generally in the community, with occasional hospitalization; and those individuals who are "difficult-to-treat," such as persons who are homeless, violent, or resistant to traditional treatment.

However, the relative inaccessibility of public care for other groups, such as those with less severe disorders or children and adolescents without seriously disruptive illnesses, will produce a demand to broaden the system. And the growing cost of concentrating on the most difficult and most expensive patients is also likely to produce a demand for effective and efficient methods of care and treatment.

What Will the Mental Health System Look Like?

The role of the private sector in mental health services will continue to increase. The emphasis on dispersion and flexibility of services, together with the growing capital and operational cost of program operation, will spur increasing interest in public contracting for private provision of mental health services. The former director of the National Institute of Mental Health has predicted that, by the year 2000, most state governments will have gotten out of the business of being direct providers of mental health services.[2]

The system will continue to become more decentralized, and, if present trends continue, a polarization may also take place. Acute mental health care could become more medicalized, typically in local general hospitals. Long-term mental health care would become less medicalized, with an emphasis on varied providers at lower cost, responding to the needs of numerous nonsubsidized

clients. Strenuous efforts will be made to access services through broad-based programs such as housing, income support, and social services.

As more patients receive services in the community, a different role is emerging for state hospitals. Many now focus on acute care, along with longer-term care for those needing greater security. As this role evolves, smaller facilities may be needed, as well as reexamination of staffing patterns, training requirements, building design, and civil commitment policies.

Both primary consumers and their families are establishing innovative self-help programs and strategies, either to supplement or to substitute for traditional mental health and related services. Support for such efforts will expand, as a cost-effective way to ease the burden without creating state services. This will entail development of nontraditional funding mechanisms.

Who Will Finance Care and How?

The likelihood of a lengthy period of pressure on resources by different public constituencies is strong. This suggests continued development of the types of financial and cost-containment strategies that are emerging today, such as capitated mental health care.

While private sector interest in providing certain forms of mental health care has increased, this generally does not extend to long-term treatment or to the uninsured or most difficult patients, who are presumed to remain a state responsibility. And the increasing emphasis on cost-containment strategies may in fact eliminate access to some health care services in the community now utilized by mental health clients. The uninsured, chronically ill, or violent are unlikely priorities for private, profit-oriented health care organizations.[3]

In the public sector, managed care options, including Health Maintenance Organizations, Preferred Provider Organizations, and various forms of capitation, are now making their way from the health to the mental health arena. While there are some particular problems in applying such strategies to mental health care, the trend is likely to continue in response to resource constraints.

The federal role is likely to focus on existing resources and supports, such as Medicaid and Social Security Disability. There will be an increased demand for small, targeted funding programs, such as resources allocated for special needs or populations. The major public financial responsibility is likely to fall, even more than today, on the states.

How Will the System Be Held Accountable?

The rapid evolution of information systems presents a real opportunity to improve system accountability. A dispersed and decentralized mental health system, with increased emphasis on the individual client, will present significant challenges in the creation of data systems to track and to measure program operation and performance and to determine the outcome of interventions for the individuals they are meant to serve. Such systems are a prerequisite to judging whether policies are producing desired results and to suggesting needed changes over time.

A growing concern about "outcome evaluation" and treatment effectiveness is also likely to continue. More demands will be placed on the system, and more information will be available to answer questions from consumers, families, communities, insurors, and policymakers. While this increased accessibility to data will lead to more difficult questions, it is also likely to assure a broader public understanding of the mental health system.

What Will Be the Role of States in Mental Health Services?

States will continue to play a central, but changing role in the future of mental health services, reducing their responsibilities as a service provider. This will allow states to play more effective and more appropriate roles in a variety of areas:

- Long range planning;
- Cost containment;
- Purchasing of services to fill gaps for underserved populations;
- Quality assurance;
- Public education and prevention;
- Development of incentives for community programs, both public and private, to serve the most needy; and
- Evaluation and accountability.[4]

Conclusion

The actual future of mental health services will reflect the impact of trends and forces beyond the control, or even the view, of policymakers. Perhaps the most important challenge faced by those with responsibility for mental health policy is the creation

of a coherent understanding of the many elements and forces bearing on the need for and provision of mental health services. This can be the first step toward agreement on a desired direction toward a better mental health system.

Notes

1. Some of the recent studies were in New York (25%), Boston (26%), Los Angeles (28%), Ohio (31%), Baltimore (37%), Milwaukee (40%), and Providence (24%). Information obtained from CHAMP, the Clearinghouse on Homelessness Among Mentally Ill People, 8630 Fenton St., Silver Spring, Md., 20910.

2. Shervert H. Frazier, M.D., "Trends in the American Mental Health System," Presentation at the 7th Annual William E. Schumacher, M.D., Distinguished Lecture Series, Portland, Maine, November 24, 1986.

3. Richard C. Surles, Ph.D., "Changing Organizational Structures and Relationships in Community Mental Health," Proceedings of the State-of-the-Art Symposium on Mental Health Administration, National Institute of Mental Health and American College of Mental Health Administration, Washington, D.C., March 11-12, 1986.

4. Frazier, "Trends in the American Mental Health System."

137

Mental Health Information Sources

General Information and Technical Assistance

Center for Change Through Housing and Community Support
University of Vermont, Department of Psychology
John Dewey Hall
Burlington, VT 05405
802/656-0000

National research, training, and technical assistance organization specifically focused on the housing and support needs of persons with major mental illness, their families, and local communities. Provides planning assistance, help with needs assessment, financing, and service development.

Center for Psychiatric Rehabilitation
Boston University
730 Commonwealth Avenue
Boston, MA 02215
617/353-3549

Develops training materials, conducts technical assistance, and offers professional training in psychiatric rehabilitation. Publishes a variety of literature on mental health issues, including a newsletter, *Community Support Network News*.

Clearinghouse on Homelessness Among Mentally Ill People
Macro Systems, Inc.
8630 Fenton Street
Silver Spring, MD 20910
301/588-5484

The only national information clearinghouse focused specifically on issues and programs related to people who are both homeless and experiencing serious mental illness. Maintains a computerized data base of published and unpublished materials.

The Information Exchange on Young Adult Chronic Patients
P.O. Box 1945
New City, NY 10956
914/634-0050

Sponsors research on young adult chronic patients and the development of effective programs and provides education and consultation about the population and effective ways of meeting their needs.

Intergovernmental Health Policy Project
George Washington University
2011 I Street, N.W.
Suite 200
Washington, DC 20006
202/872-1445

Produces a monthly newsletter—*State Health Reports: Mental Health, Alcoholism and Drug Abuse*—concerning state legislation, reports and studies, and other pertinent mental health information.

Mental Health Policy Resource Center
1100 17th Street, N.W.
Suite 901
Washington, DC 20036
202/775-8826

Designs and produces materials to support policy decision-making and to improve the information base for mental health policy process.

Mental Health Policy Studies
University of Maryland School of Medicine
Department of Psychiatry
645 West Redwood Street
Baltimore, MD 21201
301/328-6902

Provides research, technical assistance, and publications in policy analysis, research and evaluation, and organizing and financing mental health services, with expertise in public services and mental health care financing, deinstitutionalization, and care of those with serious mental illness.

National Association of Counties
Mental Health Project
440 1st Street, N.W.
Washington, DC 20001
202/393-6226

Provides technical assistance to counties in three areas: farm crisis and rural mental health, mentally ill persons in jails, and dually diagnosed mentally ill. Also produces fact sheets and exemplary program documents on each topic.

National Association of State Mental Health Program Directors
1001 Third Street, Suite 114
Washington, DC 20024
301/554-7807

Monitors federal and congressional activities and gathers and analyzes information on state government mental health programs. Also has divisions of state mental health attorneys, forensic directors, and children and youth representatives. Publishes a regular information newsletter, *NASMHPD Studies*.

National Conference of State Legislatures
Mental Health Project
1050 17th Street, Suite 2100
Denver, CO 80265
303/623-7800

Provides specialized technical assistance to five legislatures each year on state-specific mental health issues, including testimony, special workshops and seminars, and individualized assistance. Also produces a variety of mental health information materials and publications, including *State Legislative Reports*, books, a resource directory, magazine articles, and monographs.

National Technical Assistance Center for Mental Health Planning
1735 Eye Street, N.W.
Suite 613
Washington, DC 20003
202/728-3939

Provides technical assistance to states and counties to improve and expand comprehensive community-based mental health systems. Primary services include state consultation, planning workshops, planning development documents, and production of a triannual newsletter, *Mental Health Planning News*.

Research and Training Center to Improve Services for Seriously Emotionally Disturbed Children and Adolescents
Florida Mental Health Institute
13301 North 30th Street
Tampa, FL 33612
813/974-4500

Conducts a variety of research training, consultation, and dissemination activities designed to increase the knowledge base in the children's mental health field. In addition to producing numerous publications, distributes a quarterly newsletter, *Update*.

Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families
Portland State University
Regional Research Institute for Human Services
P.O. Box 751
Portland, OR 97207
503/229-4040

Conducts research on ways to improve services to help emotionally disturbed children; develops training materials and programs for professionals, parents, and employers; and serves as an information center. Also produces a quarterly newsletter, *Focal Point*.

140

Robert Wood Johnson Foundation
The Program for the Chronically Mentally Ill
Massachusetts Mental Health Center
74 Fenwood Road
Boston, MA 02115
617/738-7774

Provides approximately $28 million in grants and low-interest loans to nine of the nation's 60 largest cities to establish a comprehensive system of care for chronically mentally ill persons. The initiative is co-sponsored by the Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development. Produces a quarterly newsletter, *InSites*.

Western Interstate Commission on Higher Education
Mental Health Program
P.O. Drawer P
Boulder, CO 80301
303/497-0250

Provides assistance with mental health state policy within the western states, particularly with staffing and workforce issues and management information systems. Publishes a quarterly newsletter, *Human Resource Development Network*.

Advocacy

American Mental Health Fund
P.O. Box 17389
Washington, DC 20041
703/573-2200

Advocacy organization that raises funds to support research and public education programs.

Children's Defense Fund
122 C Street, N.W.
Washington, DC 20001
202/628-8787

Conducts research and publishes information on issues affecting children; monitors governmental policies; provides technical assistance, information, and support; and litigates select issues.

National Alliance for the Mentally Ill
1901 North Fort Myer Drive, Suite 500
Arlington, VA 22209
703/524-7600

Alliance of self-help and advocacy groups concerned with improving services to those with severe and chronic mental illness. Produces a newsletter, *NAMI News*, and other mental health publications.

National Consortium for Child Mental Health Services
3615 Wisconsin Avenue, N.W.
Washington, DC 20016
202/966-7300

Provides a forum of information exchange on child mental health services and brings concerns regarding child mental health services to appropriate local, state, and federal agencies.

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314
703/684-7722

Consumer advocacy organization that serves as a central national source for information on mental illness and mental health.

National Mental Health Consumer's Association
311 South Juniper Street
Room 902
Philadelphia, PA 19107
215/735-2465

Promotes information sharing among self-help groups through education and clearinghouse activities.

Legal Organizations

American Bar Association
Commission on Mentally Disabled
1800 M Street, N.W.
Suite 200
Washington, DC 20036
202/331-2240

Helps mentally disabled individuals obtain adequate treatment in humane environments and safeguards basic rights. Provides legal research services, produces publications on a variety of mental health issues, and publishes the *Mental and Physical Disability Law Reporter* bimonthly.

Mental Health Law Project
2021 L Street, N.W., Suite 800
Washington, DC 20036
202/467-5730

Clarifies, establishes, and enforces the legal rights of mentally and developmentally disabled through test case litigation, technical assistance to direct service advocates, and policy advocacy at federal and state levels.

National Center for State Courts
Institute on Mental Disability and the Law
300 Newport Avenue
Williamsburg, VA 23185
804/253-2000

Conducts applied research and program evaluations, provides consultation services, produces publications, and serves as a clearinghouse of information for state courts in the areas of mental disability and the law.

Professional Organizations

American Mental Health Counselors Association
599 Stevenson Avenue
Alexandria, VA 22304
703/823-9800

Professional organization for counselors employed in mental health services. Sponsors educational programs, compiles statistics, and assists with the certification process.

American Orthopsychiatric Association
19 West 44th Street, #1616
New York, NY 10036
212/354-5770

Fosters research and disseminates information concerning scientific research in mental health for related professions.

American Psychiatric Association
1400 K Street, N.W.
Washington, DC 20005
202/682-6000

Membership organization for psychiatrists that formulates programs to meet mental health needs, compiles data on psychiatry and furthers education and research.

American Psychological Association
1200 17th Street, N.W.
Washington, DC 20036
202/955-7600

Scientific and professional society of psychologists. Produces and disseminates numerous publications concerned with mental health issues.

Association of Mental Health Administrators
840 North Lake Shore Drive, Suite 1103W
Chicago, IL 60611
312/943-2751

Membership organization of service administrators for the emotionally disturbed, mentally ill, developmentally disabled, and substance abusers to further education and develop professional certification.

National Association of Social Workers
7981 Eastern Avenue
Silver Spring, MD 20910
301/565-0333

Membership organization of social workers and those concerned with social work practice. Has a commission on health and mental health.

Provider Organizations

American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611
312/280-6000

Represents individuals and health care institutions and carries out research, provides education projects, and collects and analyzes data.

International Association of Psychosocial Rehabilitation Services
P.O. Box 278
McLean, VA 22101
703/237-9385

Membership organization of professionals serving adults with psychiatric disabilities and providing social and recreational, vocational, residential, and educational services. Provides technical assistance to organizational members.

The National Association of Private Psychiatric Hospitals
1319 F Street, N.W.
Washington, DC 20004
202/393-6700

Voluntary organization of 240 freestanding, nongovernmental psychiatric hospitals devoted exclusively to the treatment of persons with mental illness.

National Association of Rehabilitation Facilities
P.O. Box 17675
Washington, DC 20041
703/556-8848

Represents agencies operating established medical and vocational rehabilitation facilities for handicapped persons in the U.S. and Canada.

National Council of Community Mental Health Centers
6101 Montrose Road, Suite 360
Rockville, MD 20852
301/984-6200

Composed of community mental health centers, organizations, agencies and interested individuals. Provides workshops, publications and technical assistance on community mental health issues, including rural issues through the National Association for Rural Mental Health.

Government Organizations

National Clearinghouse for Drug Abuse Information
P.O. Box 416
Kensington, MD 20795
301/443-6500

Provides information on drug abuse and drug dependence and the use and misuse of prescribed medicines.

National Clearinghouse for Mental Health Information
National Institute of Mental Health
5600 Fishers Lane, Room 11 A 33
Rockville, MD 20857
301/443-4517

Provides information on all areas of mental health and mental illness.

National Institute of Mental Health
5600 Fishers Lane
Rockville, MD 20857

Supports and conducts research in universities, hospitals, and other facilities throughout the country on mental illness and its treatment. In addition, provides information, training, and research on resource management, epidemiology, and service systems.

National Rehabilitation Information Center
4407 8th Street, N.E.
Washington, DC 20017
202/635-5826

Provides information on rehabilitation of disability groups, on professional and administrative practices, and on current rehabilitative activities and issues for rehabilitation professionals, disabled persons, and the general public.

Glossary

Acute—Severe but of short duration; not chronic.

Advocacy—Activities in support of individuals with mental illness, including rights protection, legal and service assistance, and system or policy change.

Alcohol, Drug Abuse, and Mental Health Block Grant (ADM)—Created by the Omnibus Budget and Reconciliation Act of 1981 (OBRA), which consolidated federal funding programs into a block grant to each state.

Alzheimer's Disease—Disease that produces intellectual impairment and is now recognized as the common cause of severe intellectual impairment in older individuals.

Block Grant—Although there is no precise definition, in general, block grants include a broad range of related activities with less precise purposes, are subject to relatively few federal regulations, and are provided to states in a lump sum with no federal approval required for expenditures.

Board and Care Home—A non-Medicaid certified residential facility in which three or more persons receive room, board, and some protective oversight. Personal care boarding homes include a wide variety of facilities and can range from rooming houses to large, well-organized, and professionally administered group homes.

Bonds—A type of debt financing in which the money to pay for a project is borrowed through the sale of bonds and paid back over time.

Capitation—A form of cost containment that pays for a service based on a set rate per person per time period.

Case Management—Services that link the individual with appropriate service programs, monitor progress, and provide advocacy services.

Categorical Grant—Federal money given to the states for a specific set of purposes, subject to a relatively large number of federal regulations. In contrast to block grants, categorical grants require some sort of federal approval of a plan before money is spent and are subject to extensive reporting requirements and program audits.

Clinic Option—Outpatient mental health services provided under the direction of a physician in a community mental health center or clinic that is not part of a hospital. Such services are reimbursed by Medicaid.

Cluster Groups—A group of state and/or local agencies that cooperate to plan and provide services for difficult-to-serve populations.

Community Development Block Grant—Provides funds through the Department of Housing and Urban Development to purchase, build, or rehabilitate properties that would benefit low- and moderate-income persons.

Community Mental Health Boards—Appointed or elected entity responsible for overseeing the local community mental health system.

Community Mental Health Centers—Public or private nonprofit legal entity through which comprehensive mental health services are provided to residents of a geographic catchment area.

Community Mental Health Centers Act—Federal legislation that authorized federal funding for the creation of comprehensive community-based mental health centers. Such centers were mandated to provide a specific set of services in a geographic catchment area, but could provide other services on a discretionary basis. Federal funding for each center declined over an eight-year time period, and each center eventually was funded mostly through other sources. The act was significantly amended by the Mental Health Systems Act of 1980 and repealed by the Omnibus Budget Reconciliation Act of 1981.

Community Support Program—A system of services to meet the needs of children and adults with serious mental illness who are capable of living in the community with appropriate rehabilitation and support services.

Consolidated Omnibus Budget Reconciliation Act (COBRA)—A package of changes enacted in 1985 that, among other things, would respond directly to many of the criticisms that have been leveled against the fiscal regulations for home- and community-based services waivers.

Continuous Treatment Teams—A team of mental health professionals responsible for the client in all settings.

Continuum of Care or Services—A range of services—including medical, psychological, prevocational, vocational, educational, recreational, social, and residential—that enable a person to progress and maintain the highest possible level of functioning.

Daily Living Skills Training—Training or retraining in basic skills of daily living in actual living situations, such as cooking, shopping, budgeting, cleaning.

Day Treatment and Partial Hospitalization Program—A program designed to provide individualized therapy and rehabilitation for persons making a transition from inpatient care to a less intensive form of care or services, or as an alternative to inpatient care. This program is designed to treat mental health problems as well as increase basic coping, social, and vocational skills.

Decentralization—Trend in the mental health delivery system to place responsibility for mental health care and spending at the local level.

147

Deinstitutionalization—Preventing unnecessary retention in and admission to public mental hospitals through the timely discharge of admitted patients and the diversion of potential candidates for admission to other treatment services and facilities. With the passage of the Community Mental Health Centers Act of 1963, deinstitutionalization of mentally disabled persons became a national mental health policy.

Diagnostic Related Groups (DRG)—Method of classifying patients into categories on the basis of diagnosis and treatment. This method is utilized in the prospective payment system employed by the federal government to pay for hospital care of Medicare patients.

Discharge Plan—A plan that identifies a hospital patient's needs, assesses available family and community resources, and prepares and refers the patient for admission to other services. Part of the continuum of care, the plan ideally begins upon a patient's admission to a residential treatment facility.

Dually Diagnosed Patient—Individual who has co-existing disorders, such as a psychotic disorder combined with substance abuse, mental retardation/developmental disability, or physically handicapping condition.

Entitlements—A specific set of services provided through a voucher system or social insurance program. The consumer is restricted to a set of services and providers, such as Medicaid, Medicare, and prepaid health insurance programs.

Evaluation—The systematic collection and analysis of data undertaken to determine the value of a program to aid in policy formation, program design, and management.

Freedom-of-Choice Waiver—Permits states to restrict the service providers that a Medicaid recipient can use, if certain conditions are met.

Group Home—Small community-based residential facility intended for disabled individuals who are capable of living in the community, but whose mental health problems or other disabilities prevent them from living independently. Usually such facilities have a 24-hour staff.

Halfway House—Place where persons are aided in readjusting to society following a period of imprisonment, hospitalization, etc.

Health Maintenance Organization (HMO)—Organized system for providing health care in a geographic area, which assures the delivery of a set of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of persons. Services are reimbursed through a predetermined, fixed, periodic prepayment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amounts of actual services provided.

Home- and Community-Based Services Waiver—Allows Medicaid dollars to provide a broad range of home and community services to persons who otherwise would require care in an institutional setting.

Income Supports— A direct transfer of cash from government to the individual. The government determines eligibility and amount of funds to be given to individuals. Cash transfers—such as SSI, SSDI, welfare, and food stamps—are helpful in assisting individuals in obtaining nonmedical supports, such as food and shelter.

Institution for Mental Disease (IMD)—Any residential facility established primarily to treat those with mental illness.

Intermediate Care—Health-related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility is designed to provide, but who, because of mental or physical condition, require 24-hour availability of nursing care and other services that can be made available only through institutional facilities.

Intermediate Care Facility (ICF)—An institution licensed under state law to provide health-related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility provides.

Involuntary Civil Commitment—Standards that permit a state to hospitalize persons who are mentally ill or substance abusers against their will because they pose a danger to self or others.

Involuntary Outpatient Treatment—Enables courts to compel outpatient treatment for those with mental illness who need treatment but who are incapable of deciding voluntarily to seek or comply with treatment orders.

Joint Commission of Mental Illness and Health—Created in 1955 to analyze and evaluate needs and resources of persons with mental illness within the United States and make recommendations for a national mental health plan.

Least Restrictive Setting—A therapeutic or caregiving setting that limits a person's freedom of movement as little as possible.

Long-Term Care—Health and/or personal care services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded, and mental hospitals.

Managed Care—A health care delivery system that attempts to keep costs down by "managing" the care to eliminate unnecessary treatment and reduce expensive hospital care. The most familiar models are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Mandated Mental Health Insurance—State laws requiring insurance companies to offer or provide minimum mental health benefits.

Matching Funds—Incentive for local government to raise local dollars for the provision of services.

Medicaid—Federal program that provides health insurance to low-income families who meet certain categorical and financial criteria.

Medicaid Waiver—Provision of Omnibus Budget and Reconciliation Act of 1981, which allowed for a waiver of regulations prohibiting Medicaid reimbursements for certain community-based services. Waivered services must be necessary to prevent institutionalization and cannot include room-and-board costs.

Medicare (Title XVIII of the Social Security Act)—Part A provides Hospital Insurance Benefits for the Aged and Disabled. Part B is a voluntary program providing supplementary Medical Insurance Benefits for the aged and disabled.

Mental Health Authority—A government entity or a nonprofit corporation designated to assume organizational, clinical, and fiscal responsibility for mental health services in a given area.

Mental Health Systems Act—Law that extended and amended the Community Mental Health Centers Act in 1980. In addition to assistance for community mental health centers, it emphasized assistance for individuals with serious mental illness, mental health services for the elderly, and an increased role for the states in the delivery of mental health services. The law also made a general provision that states should ensure that mental health patients receive the protection and services they require. This was repealed by the Omnibus Budget and Reconciliation Act of 1981 and succeeded by the Alcohol, Drug Abuse, and Mental Health Services block grant.

Mentally Ill Offender—A person with a mental illness who has been arrested on charges that are more related to the illness than to criminal intent, such as loitering, disturbing the peace, and trespassing.

National Mental Health Act—Created the National Institute of Mental Health in 1946, giving the federal government responsibility to assist in developing state and community mental health services, to support mental illness research, and to support training in the mental health profession.

Needs Assessment—A study that attempts to identify the service needs of populations or special subgroups. A needs assessment may also include an examination of services that are already in place and an identification of service gaps.

Omnibus Budget and Reconciliation Act of 1981—Massive reform to decentralize administration and funding of health and social service programs from the federal to the state level of government. It was felt that states are in the best position to identify the needs of their respective populations and should play a more substantial role in the decision-making process.

Outreach—Efforts to locate persons with mental illness, inform them of available services, and assure access to needed services and community resources by arranging transportation or by taking the services to the client.

Performance Contract—An agreement under which the funding agency establishes criteria, standards, or both, with which the contractor agrees to comply in order to qualify for funds.

Pre-emptive Doctrine—When state law supercedes any local laws; e.g., state zoning laws can take precedence over any local zoning laws.

Preferred Provider Organization (PPO)—A limited network of physicians and hospitals that have formally agreed to provide certain health care services to specified insured populations at previously negotiated rates. These hospitals and physicians contract on a fee-for-service basis with large employers, insurance carriers, or third-party administrators to provide comprehensive medical services to subscribers.

Program Performance Measures (or Indicators)—Quantitative, objective agreed-upon measures to indicate how well a program or organization is functioning.

Prospective Payment—Method of determining payments for medical care in advance of delivery of services.

Psychosocial Rehabilitation—Traditional mental health services, as well as a variety of social learning, vocational, and community living programs.

Psychotropic Medication—Drugs that are prescribed by physicians to control some of the symptoms of mental illness.

Recreational and Socialization Services—Structured activities for clients that promote the development of appropriate social skills.

Rehabilitation Act of 1973, Section 504—This section prohibits discrimination on the basis of physical or mental handicap in every federally assisted program or activity in the country.

Rehabilitation Services—Services specifically tailored to assist a disabled person to improve physical, psychosocial, and vocational functioning. Provides assistance in job training, education, community support, transportation, living skills, and other basic needs.

Residential Facility—Living arrangements in the community for persons needing some supervision and support, ranging from 24-hour care to almost total independence.

Respite Care—A service designed either to provide temporary residence for a disabled person who ordinarily lives with family or friends or to assume temporary responsibility for care of the person in his or her own home. Provides back-up support and in some cases a "vacation" to persons responsible for care of an ill or disabled person who ordinarily lives in their household.

Revolving Door Syndrome—Repeated cycling into and out of inpatient facilities, caused by inadequate services and insufficient coordination.

Risk Pool—A health insurance pool responsible for people unable to obtain conventional coverage. Typically, all insurers doing business in the state are required to join the pool and offer health insurance to people considered uninsurable.

Section 8/202 Housing Assistance Payments Program—A program of rent subsidies for elderly or handicapped persons residing in existing, newly constructed, or substantially rehabilitated housing.

Self-Help—The means through which mental health consumers, families, or friends contact each other to share their experiences and suggest strategies for coping or for change.

Seriously or Chronically Mentally Ill—Term used to describe persons who suffer certain mental or emotional disorders that erode or prevent the development of their functional capacities in relation to such primary aspects of daily life as personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation and that erode or prevent the development of their economic self-sufficiency. Many persons with serious mental illness require institutional care of extended duration, short-term hospitalization, and outpatient treatment.

Sheltered Workshop—A job situation that is structured for those with serious mental illness, including individualized vocational rehabilitation, prevocational testing, and protective oversight.

Short-Term Care—Care and treatment provided for short durations of time, usually not exceeding 30 days in length.

Single Point of Authority—Authority responsible for all mental health funding and delivery of services.

Single Room Occupancy (SRO)—Refers to hotels, often in decaying urban areas, in which large numbers of persons with serious mental illness reside, many on welfare or some type of income assistance.

Skilled Nursing Facility—An institution that has a transfer agreement with one or more participating hospitals, and is primarily engaged in providing to inpatients skilled nursing care and rehabilitative services; meets specific regulatory certification requirements.

Social Security Disability Insurance (SSDI)—Disability insurance payments to the disabled who have been forced to retire prematurely because of disability, but who have contributed through their employment to the disability fund.

Social Services Block Grant—Created by the 1981 Omnibus and Reconciliation Act to consolidate federal assistance to states for social services into a block grant that allows states to use the money for almost any community or social services for virtually any individual or family.

Soft Match—Practice in which state funds are reallocated from an existing fully funded state or local program and utilized as match funds for new or expanded Medicaid services.

State Hospital—Facility that provides acute or long-term inpatient care and is supported primarily through state appropriations.

Supplemental Security Income (SSI)—A program of income support for low-income aged, blind, and disabled persons, established by Title XVI of the Social Security Act.

Supported Employment—Program that assists handicapped individuals to obtain work in competitive environments with continuing supportive services.

Third-Party Payor—Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients.

Young Adult Chronic Patient—Individuals 18-35 years old who suffer from a mental illness or personality, affective, or other psychotic disorder that seriously interferes in various aspects of social functioning over a long period of time. May never have been hospitalized and frequently eludes the mental health service system.

Zoning—A type of land-use contract derived from public legislative bodies and most often implemented at the local level. Local zoning regulations have effectively excluded or restricted community homes for the disabled from residential areas.

Acronyms

ABA	American Bar Association
ADAMHA	Alcohol and Drug Abuse and Mental Health Administration
ADM	Alcohol, Drug Abuse, and Mental Health Block Grant
AFDC	Aid to Families with Dependent Children
BC/BS	Blue Cross and Blue Shield Association
CASSP	Child and Adolescent Service System Program
CMHC	Community Mental Health Center
CMI	Chronically Mentally Ill
COBRA	Consolidated Omnibus Budget and Reconciliation Act
CSP	Community Support Program
DRG	Diagnostic Related Group
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
HUD	Department of Housing and Urban Development
ICF	Intermediate Care Facility
IMD	Institution for Mental Disease
NACO	National Association of Counties
NASMHPD	National Association of State Mental Health Program Directors
NCSL	National Conference of State Legislatures
NIMH	National Institute of Mental Health
OBRA	Omnibus Budget and Reconciliation Act
PPO	Preferred Provider Organization
RWJ	Robert Wood Johnson Foundation
SMHA	State Mental Health Agency
SRO	Single Room Occupancy Hotels
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
VA	Veterans' Administration

Bibliography

Aiken, Linda; Somers, Stephen A.; and Shore, Miles F. "Private Foundations in Health Affairs: A Case Study of the Development of a National Initiative for the Chronically Mentally Ill." *American Psychologist* 41, no. 11 (November 1986): 1290-1295.

Burns, Barbara J., and Schulberg, Herbert C. "Organizing Psychiatric Care in General Hospitals to Meet Medical and Psychiatric Needs." *Administration in Mental Health* 13, no. 3 (Spring 1986): 180-188.

Carling, Paul J.; Daniels, La Vonne; and Ridgway, Priscilla. *Meeting the Housing Needs of Persons with Psychiatric Disabilities: Comments on the State-of-the-Art*. Boston: Boston University Center for Psychiatric Rehabilitation, Community Residential Rehabilitation Project, July 1985.

Carter, Reginald L. *The Accountable Agency. A Sage Human Services Guide*, no. 34. Beverly Hills, Calif.: Sage Publications, 1983.

Chacko, Ranjit. *The Chronic Mental Patient in a Community Context*. Washington, D.C.: American Psychiatric Press, Inc., 1985.

Craig, Rebecca T. "Community Care for the Chronically Mentally Ill: Removing Barriers and Buildings Supports." *State Legislative Report* 11, no. 8 (revised May 1987).

_____."Making Ends Meet: Maximizing the Mental Health Dollar." *State Legislative Report* 11, no. 11 (revised December 1986).

Craig, Rebecca, and Kissel, Michelle. "The Mentally Ill Offender: Punishment or Treatment?" *State Legislative Report* 11, no. 13 (revised August 1987).

Cutler, David, ed. *New Directions for Mental Health Services: Effective Aftercare for the 1980s*. San Francisco: Jossey-Bass, Inc., 1983.

Daniels, La Vonne. "Retooling in the 80s—Transferring Dollars from Hospital to Community Programs." *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 30 (March 1987).

Denver Research Institute. *Factors Influencing the Deinstitutionalization of the Mentally Ill: A Review and Analysis*. Hyattsville, Md.: National Center for Health Services Research, April 1981.

Department of Health and Human Services, Steering Committee on the Chronically Mentally Ill. *Toward a National Plan for the Chronically Mentally Ill*. Washington, D.C.: U.S. Department of Health and Human Services, December 1980.

Dickey, Barbara, and Goldman, Howard H. "Public Health Care for the Chronically Mentally Ill: Financing Operating Costs, Issues and Options for Local Leadership." *Administration in Mental Health* 14, no. 2 (Winter 1986): 63-77.

Dolan, Lawrence W. "Reuse of State Hospital Property, 1970-1985." *Hospital and Community Psychiatry* 38, no. 4 (April 1987): 408-410.

Foley, Henry A., and Sharfstein, Steven S. *Madness and Government: Who Cares for the Mentally Ill?* Washington, D.C.: American Psychiatric Press, Inc., 1983.

Freeman, Ruth I., and Moran, Ann. "Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization." *Medical Care* 22, no. 12 (Supplement) (December 1984).

Furlong-Norman, Kathy, ed. "Young Adults with Psychiatric Disabilities." *Community Support Network News* 3, no. 2 (September 1986).

Gattozzi, Antoinette. "Prospective Payment of Mental Health Care." *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 22 (April 1986): 1-4.

Goodrick, David. "Survival of Public Inpatient Mental Health Systems: Strategies for Constructive Change." *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 11 (October/November 1984): 1-6.

Greene, Steve; Witkin, Michael J.; Fell, Adele; and Manderscheid, Ronald W. "State and County Mental Hospitals, U.S. 1982-83 and 1983-84." *Mental Health Statistical Note* No. 176. Rockville, Md.: National Institute of Mental Health (September 1986).

Hastings, Margaret. *Financing Mental Health Services: Perspectives for the 1980s*. Rockville, Md.: National Institute of Mental Health, U.S. Department of Health and Human Resources, 1986.

Intagliata, James. "Improving the Quality of Community Care for the Chronically Mentally Disabled: The Role of Case Management." *Schizophrenia Bulletin* 8, no. 4 (1982): 655-674.

Jones, Rich. "Keeping an Eye on State Agencies." *State Legislatures* 13, no. 6 (July 1987): 20-23.

Kimmel, Wayne A. *Putting Program Evaluation in Perspective for State and Local Government*. Human Services Monograph Series, no. 18. Washington, D.C.: Project Share, Department of Health and Human Services, April 1981.

Landsberg, Gerald; Neigher, William D.; Hammer, Roni J.; Windle, Charles; and Woy, J. Richard, eds. *Evaluation in Practice*. Rockville, Md.: National Institute of Mental Health, 1979.

Lang, Adrienne. "State Laws Mandating Private Health Insurance Benefits for Mental Health, Alcoholism and Drug Abuse." *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 20 (January 1986): 1-24.

Lehman, Anthony F. "Capitation Payment and Mental Health Care: A Review of the Opportunities and Risks." *Hospital and Community Psychiatry* 38, no. 1 (January 1987): 31-38.

Liberman, Robert J. et al. *Resource Book for Psychiatric Rehabilitation*. Camarillo, Calif.: Center for Rehabilitation Research and Training in Mental Illness, UCLA School of Medicine, 1984.

Lutterman, Theodore C.; Mazade, Noel A.; Wurster, Cecil R.; and Glover, Robert W. "Trends in Revenues and Expenditures of State Mental Health Agencies, Fiscal Years 1981, 1983 and 1985." *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 34 (September/October 1987): 1-6.

Manderscheid, Ronald W., and Barrett, Sally A., eds. *Mental Health, United States, 1987*. Rockville, Md.: National Institute of Mental Health, 1987.

McLaughlin, Curtis P., and Zelman, William N. "Entrepreneurship and State/Mental Health Center Relationships." *Community Mental Health Journal* 23 (Spring 1987): 60-75.

Mechanic, David. "Mental Health and Social Policy: Initiatives for the 1980s." *Health Affairs* 4 (Spring 1985).

Morrissey, Joseph P., and Goldman, Howard H. "Cycles of Reform in the Care of the Chronically Mentally Ill." *Hospital and Community Psychiatry* 35, no. 8 (August 1984).

Paterson, Andrea. "Mental Health Services Coordination: Working Towards Utopia." *State Legislative Report* 11, no. 5 (revised January 1987).

Patton, Michael Quinn. *Utilization-Focused Evaluation*. Beverly Hills, Calif.: Sage Publications, 1986.

Pepper, Bert. "Where and How Should Young Adult Chronic Patients Live? The Concept of a Residential Spectrum." *TIE Lines* 2, no. 2 (April 1985).

Pepper, Bert, and Ryglewicz, Hilary. "Designing/Redesigning Public Policy for the Chronically Mentally Ill: We Need a New Bus!" *TIE Lines* 3, no. 2 (April 1986).

Randolph, Frances L.; Laux, Bob; and Carling, Paul J. *In Search of Housing: Creative Approaches to Financing Integrated Housing*. Burlington, Vt.: Center for Change Through Housing and Community Support, University of Vermont, 1987.

Ridgway, Priscilla. "Housing and Mental Illness." *State Health Reports: Mental Health, Alcoholism and Drug Abuse*, no. 35 (November/December 1987).

Rogers, Patrick, ed. *Trends and Innovations in Mental Health*. Arlington, Va.: Capitol Publications Incorporated, 1986.

Scallet, Leslie; Radin, Beryl; Plaut, Thomas; Platman, Stanley; and Koyanagi, Chris. "Action for the Future of Mental Health." *Administration in Mental Health* 12, no. 4 (Summer 1985).

"State Hospitals and Their Role in the Continuum of Mental Health Care: State Models and Approaches." Denver, Colo.: National Conference of State Legislatures, December 1987.

Stroul, Beth A. *Models of Community Support Services: Approaches to Helping Persons with Long-term Mental Illness*. Rockville, Md.: National Institute of Mental Health, Community Support Program, August 1986.

Talbott, John A. *The Chronic Mental Patient: Problems, Solutions, and Recommendations for a Public Policy*. Washington, D.C.: American Psychiatric Press, Inc., 1978.

Toff, Gail E., and Scallet, Leslie. "Financing Community Services for Chronically Mentally Ill Individuals." *RAP: Report on Approaches to Problems*. Washington, D.C.: Policy Resources Incorporated, June 1986.

_____. "The Medicaid Waiver and Its Use in Financing Mental Health and Related Services in the Community." *RIP: Report on Issues of Policy*. Washington, D.C.: Policy Resources Incorporated, April 1986.

_____. "The Mentally Ill in Nursing Homes." *RIP: Report on Issues of Policy*. Washington, D.C.: Policy Resources Incorporated, June 1986.

Torrey, E. Fuller, and Wolfe, Sidney M. *Care of the Seriously Mentally Ill: A Rating of State Programs*. Washington, D.C.: Public Citizen Health Research Group, 1986.

"Toward a Model Plan for a Comprehensive, Community-Based Mental Health System." Rockville, Md.: National Institute of Mental Health, October 1987.

U.S. Congress, House, Committee on Government Operations. *From Back Wards to Back Streets: The Failure of the Federal Government in Providing Services for the Mentally Ill*. 100th Cong., 2d Sess., March 30, 1980.

Wallace, Cynthia. "Employers Turning to Managed Care to Control Their Psychiatric Care Costs." *Modern Healthcare* 17 (July 3, 1987): 82.

Weiss, Carol H. "Evaluation for Decisions: Is Anybody There? Does Anybody Care?" Plenary address for the meeting of the American Evaluation Association, Boston, Mass., October 16, 1987.

Williams, Sarah, ed. "Redirecting State Dollars to Build Community-based Mental Health Systems." *Alpha Centerpiece: A Report on Health Policy Issues* (October 1986).

Windle, Charles, ed. *Program Performance Measurement: Demands, Technology, and Dangers*. Rockville, Md.: National Institute of Mental Health, 1984.

Windle, Charles; Jacobs, Judith H.; and Sherman, Paul S., eds. *Mental Health Program Performance Measurement*. Rockville, Md.: National Institute of Mental Health, 1986.

Yondorf, Barbara, and Puls, Barbara. *Capital Budgeting and Finance: The Legislative Role*. Denver, Colo.: National Conference of State Legislatures, November 1987.

Zweig, Franklin M., ed. *Evaluation in Legislation*. Sage Research Progress Series in Evaluation, Vol 5. Beverly Hills, Calif.: Sage Publications, 1979.

National Conference of State Legislatures

William T. Pound, Executive Director

Denver Office
1050 Seventeenth Street, Suite 2100
Denver, Colorado 80265
303/623-7800

Washington Office
444 North Capitol Street, N.W., Suite 500
Washington, D.C. 20001
202/624-5400